

8. The Myth-Of-Mental-Illness Model: Schizophrenic Symptoms as Manufactured Artefacts

Introduction

The myth-of-mental-illness (M-M-I) model for schizophrenia should not be dismissed on the assumption that adherents to this interpretation are either few in number or socially insignificant. Recent research undertaken by Professor Robert Spillane, a lecturer in management at Macquarie University in Sydney, has found that one third of middle and senior level business managers in Sydney and Melbourne believe that "mental illnesses such as schizophrenia and manic depression are myths dreamed up by lazy workers" as excuses "used to escape work or gain personal rewards".¹

The basic premise of the M-M-I model is simply that there cannot be any disease of the mind because the mind is an abstract concept without any physical reality.² The M-M-I model argues that the use of the term 'mental disease' to describe unusual patterns of thought and behaviour was originally clearly understood as being metaphorical.³ The subsequent application of a medical model to this metaphor, and the modern literal understanding of it, is therefore unsound.⁴ A 'sick' mind, like a 'sick' joke, or a 'sick' society, cannot be treated medically and would only be literally understood as a medical problem by a fool.

From the M-M-I perspective the only way that the symptoms of schizophrenia can be indicative of disease is if they are manifestations of a brain disease, not a mental disease.⁵ However, despite the many hypotheses which try to link schizophrenia with brain abnormalities, no firm pattern of schizophrenia-typical lesions has yet been detected in the brains of deceased schizophrenics so there is no evidence that the diagnostic indicators of schizophrenia are symptoms of brain disease.⁶ Therefore, there is no such thing as a brain disease, let alone a mental disease, called schizophrenia: "Schizophrenia is a moral verdict masquerading as a medical diagnosis".⁷

¹ 'Mental illness myth: bosses', Sunday Telegraph (Sydney), 19 September, 1999.

² Thomas Szasz, The Myth of Mental Illness, Revised Edition, Harper and Row, New York, 1974, pp. vii-xii.

³ Thomas Szasz, 'Diagnoses are not diseases', The Lancet, Vol. 338, No. 8782, December 21, 1991, pp. 1574-1577

⁴ William J. Gannon, 'The formulated fix: The role of reification in the diagnostic process', Psychology, Vol 21, Nos. 3 and 4, 1984, pp. 43-48.

⁵ Thomas Szasz, Schizophrenia: The Sacred Symbol of Psychiatry, Syracuse University Press, Syracuse New York, 1976, pp. 34-35.

⁶ Theodore R. Sarbin, 'Towards the Obsolescence of the Schizophrenia Hypothesis,' The Journal of Mind and Behaviour, Vol. 11, Nos. 3 and 4, 1990, pp. 259-283.

⁷ Theodore R. Sarbin and James C. Mancuso, Schizophrenia: Medical Diagnosis or Moral Verdict?, Pergamon Press, New York, 1980, p. 220.

The common incidence of people supposedly displaying schizophrenic indicators does not threaten the M-M-I argument. On the one hand it can be argued that schizophrenic indicators fall within the range of natural psychological and behavioural experience and they have only been defined in pathological terms because they fall outside the boundaries of cultural tolerance.⁸ As such there are social expectations that ‘good citizens’ will avoid these patterns of thought and behaviour. People who do not avoid them are subsequently identified as deviants because, in a metaphorical sense, they have ‘sick’ minds.⁹

On the other hand it can also be argued that a provision by the medical profession of an otherwise non-existent category of human types called schizophrenics has required that individuals of this type be manufactured to fill it. To describe how this manufacturing process takes place analogies are drawn between modern schizophrenics and medieval witches.¹⁰ Just as it is now thought to be unlikely that people with magical powers of communication, and a compulsive desire to corrupt Christian citizens, actually existed in late-medieval Europe, so it is also thought unlikely that people actually manifest the extraordinary mental contortions, and compulsive forms of dangerous behaviour, attributed to modern schizophrenics.¹¹

What brings these types of people into existence is the human imagination. Belief in their existence is a kind of shared collective delusion, which fulfils transitory cultural needs, and which can be initiated when the holders of epistemological authority categorically assert that such things are true.¹² In other words, these culturally-based delusions are initiated when transmission of the false belief is from the top down.

In the case of late-medieval witches this occurred with the publication of the *Malleus Maleficarum* in 1486. The *Malleus Maleficarum* was a precise diagnostic manual for witch-hunters¹³ and it was published specifically to implement a papal bull empowering Inquisitors “to proceed to the just correction, imprisonment, and punishment”¹⁴ of heretics who corrupted the Catholic faith by

⁸ Seth Farber, *Madness, Heresy, and the Rumor of Angels: Revolt Against the Mental Health System*, Open Court, Chicago, 1993, pp. 1-3.

⁹ Ariel Stravynski and Kieron O'Connor, ‘Understanding and managing abnormal behaviour: the need for a new clinical science’, *The Journal of Psychology*, Vol. 129, No. 6, pp. 605-621.

¹⁰ Thomas Szasz, *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement*, Paladin, St Albans, 1973.

¹¹ D. L. Penn, K. Guynan, T. Daily, W. D. Spaulding, C. P. Garbin, M. Sullivan, ‘Dispelling the Stigma of Schizophrenia: What Sort of Information is Best?’, *Schizophrenia Bulletin*, Vol. 20, No. 3, 1994, pp. 567-78.

¹² Stravynski and O'Connor, *op.cit.*, pp. 605-621.

¹³ G. Zilboorg, *A History of Medical Psychology*, Norton, New York, 1967, pp. 144-174.

¹⁴ *Malleus Maleficarum*, quoted in Szasz, *The Manufacture of Madness*, *op.cit.*, p. 35.

conversing with devils. After its publication “there soon followed an epidemic of Witchcraft”¹⁵ and people manifesting the malignant signs were discovered everywhere.

In the case of modern schizophrenics the official declaration of their imagined existence can not be so easily dated to a single publication. Kraepelin’s and Bleuler’s seminal works were part of an evolving definition of pathology to which many other researchers had contributed before them.¹⁶ The evolution of the medical model for schizophrenia has already been discussed and, as befits a scientific enterprise, the exact details of the definition of schizophrenia shift as new knowledge is negotiated into existence.¹⁷ To be valuable as scientific knowledge the belief in schizophrenia must support on-going scientific research. Ongoing scientific research inevitably keeps the definition moving. This movement gives rise to the illusion that progress is being made in the discovery of knowledge about the subject and that break-throughs are imminent.¹⁸

From the M-M-I perspective schizophrenia research is highly doubtful since it can only be founded on false assumptions. If the indicators of schizophrenia are actually quite natural forms of human expression, which are only made abnormal by cultural restrictions, nothing more can be discovered about schizophrenics beyond what is already self-apparent: i.e. that they are people who do not conform with unwritten codes of behaviour. On the other hand, if the supposed signs and symptoms are truly extraordinary, like the ones that were supposed to identify witches, then they actually exist in the minds of the observers of schizophrenia, not in the minds of the schizophrenics. If this is the case then we are confronted with the paradox that the minds which are routinely distorting reality are, in response to these distortions, researching into a non-existent disease by examining and deliberately modifying minds which would otherwise be quite normal. Once again the persecution of witches by the Inquisition is a useful analogy.

Some of the M-M-I case-studies of schizophrenics demonstrate the persuasive power of both these points of view.¹⁹ That is, although some people might have a perfectly rational explanation for being the way they are, they might be diagnosed with schizophrenia when they antagonise other

¹⁵ Szasz, ibid.

¹⁶ Anthony Clare, Psychiatry in Dissent: Controversial issues in thought and practice, Second Edition, Tavistock, London, 1980, pp. 120-168.

¹⁷ For a discussion on the way in which scientific knowledge is negotiated into existence see, H. Tristram Engelhardt, Jr., and Arthur L. Caplan, ‘Patterns of controversy and closure: the interplay of knowledge, values, and political forces’, in H. Tristram Engelhardt, Jr., and Arthur L. Caplan, eds., Scientific Controversies: Case studies in the resolution and closure of disputes in science and technology, Cambridge University Press, Cambridge, 1987, pp. 1-23.

¹⁸ Daniel R. Weinberger, ‘From neuropathology to neurodevelopment: Schizophrenia, Part 2’, The Lancet, Vol. 346, No. 8974, August 26, 1995, pp. 552-558.

¹⁹ See for example, Seth Farber, Madness, Heresy, and the Rumor of Angels: Revolt Against the Mental Health System, Open Court, Chicago, 1993.

people by being deliberately and defiantly different.²⁰ As well as this, seemingly ordinary people, who demonstrably want to be normal and well-liked by others, can also be diagnosed.²¹ This might happen when too much stress builds up in a group, particularly a family,²² and it is necessary to nominate a convenient scape-goat. When this happens these otherwise ordinary individuals become the target for group disdain or group condescension.²³ By sacrificing one member to the mental health system the group might be able to relieve its collective stress and preserve its unity.

These kinds of M-M-I arguments are not particularly threatening to mainstream psychiatry. The medical model of schizophrenia has widespread community support²⁴ and, as a consequence, consensus within the profession is strong.²⁵ The few mental health professionals who question it have been easily marginalised.²⁶ But perhaps, paradoxically, the strength of this professional/community solidarity can be attributed to the fact that schizophrenia is indeed a myth. If the M-M-I argument is actually correct, and the process of diagnosis and treatment for schizophrenia is no more than a system for disposing of unwanted scapegoats and social deviants, then a vital social function is still being performed and one could expect it would meet with little opposition beyond the victims themselves. This could well be the reason why the M-M-I argument now appears to have very little appeal to either psychiatric professionals or ordinary people.²⁷

Nor can the M-M-I argument make any headway by demonstrating the inappropriateness of the schizophrenia label in individual cases. Where it can be convincingly demonstrated that a particular schizophrenic had a perfectly well-ordered mind at the time of diagnosis,²⁸ the psychiatric defence is simply to argue that here is an example of false-positive diagnosis, and that although medicine is not a perfect science, even so, the precision of psychiatric diagnosis is improving all the time.²⁹

²⁰ Kathleen Smith, Muriel W. Pumphrey, and Julian C. Hall, 'The "Last Straw": The Decisive Incident Resulting in the Request for Hospitalisation in 100 Schizophrenic Patients', in Richard H. Price and Bruce Denner, eds., The Making of a Mental Patient, Holt, Rinehart and Winston, New York, 1973, pp. 70-78.

²¹ See for example, Harvey Currell, Peter Bruton, and Sidney Katz, 'Psychiatric Justice in Canada', in Thomas S. Szasz, ed., The Age of Madness, Routledge and Kegan Paul, London, 1973, pp. 216-230.

²² R. D. Laing and A. Esterson, Sanity, Madness and the Family, Penguin, Harmondsworth, 1964.

²³ Irit Shimrat, 'Psychiatry: not all it's cracked up to be', Canadian Dimension, Vol. 29, No. 5, October-November 1995, pp. 10-12.

²⁴ See for example, National Association for the Mentally Ill (NAMI), Schizophrenia, Information Pamphlet, June 1990.

²⁵ Melvin Sabshin, Prepared Statement for the American Psychiatric Association, before the House Appropriations Committee Labor, Health and Human Services and Education Subcommittee, Wednesday, April 16, 1997, Federal News Service - Congressional Hearing Testimonies.

²⁶ Genevieve Stuttaford, 'Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill (Book Review)', Publishers Weekly, Vol. 237, No. 28, July 13, 1990, p48.

²⁷ E. Fuller Torrey, 'The mental-health mess', National Review, Vol. 44, No. 25, Dec 28, 1992, pp. 22-26.

²⁸ Seth Farber, 'From Victim to Revolutionary: An Interview with Leonard Frank', in Seth Farber, op.cit., pp. 190-240.

²⁹ Samuel I Cohen, 'Overdiagnosis of schizophrenia: role of alcohol and drug misuse', The Lancet, Vol. 346, No. 8989, Dec 9, 1995, pp. 1541-1543.

An often-cited weakness in M-M-I argument is that a large fraction of the people designated as schizophrenics are willing to accept the label.³⁰ If schizophrenia is a myth why are so many of the supposed social deviants and scape-goats willing to identify themselves as schizophrenics, thereby endorsing their own alienation? The M-M-I response is to argue that these apparently willing schizophrenics are involved in a type of role-playing.³¹

In order to explore the soundness of the M-M-I model it is proposed in this chapter to divide the model into three sub-types. The first sub-type is the **schizophrenic-as-cultural-outsider** and is concerned with whether the signs and symptoms of schizophrenia are anything more than a transgression of the boundaries of culturally acceptable thinking and behaviour. Schizophrenics of this type are, by definition, different from normal people, but only marginally so. Sometimes they might be aware of their difference, and deliberately cultivate it,³² and sometimes they might be surprised to discover that other people perceive them as abnormal.³³ The invention of schizophrenia, and the application of its diagnoses, are seen from this angle as a method of dealing with people who have wandered outside the cultural envelope.³⁴ To test this theory the DSM-IV diagnostic criteria for schizophrenia will be examined as if they are designed to represent boundary markers of cultural tolerance.

The second sub-type will deal with the **schizophrenic-as-scapegoat**. Here the person designated as schizophrenic is himself or herself quite normal, and would otherwise be content to live within the cultural boundaries, but has the misfortune to belong to a group that is under stress. The group might be a company, a neighbourhood, or even a nation, but most frequently it is a nuclear family.

The third sub-type involves **schizophrenia-as-role-play**. This is where the symptoms of schizophrenia are simulated. The simulation might be initiated by either the patient or the diagnostician. When it is initiated by the patient it could be motivated by the desire to adopt the schizophrenic role as a career. When the role-playing is initiated by the diagnostician it might involve the maintenance of professional norms. Either way the result can be that the person who receives the diagnosis also receives a detailed script describing how to think and behave like a

³⁰ See for example, Jim Read and Jill Reynolds, eds., Speaking Our Minds: An Anthology of Personal Experiences of Mental Distress and its Consequences, The Open University, London, 1996.

³¹ Thomas Szasz, 'Idleness and Lawlessness in the Therapeutic State', Society, Vol. 32, No. 4, 1995, p. 30-36.

³² See for example, Vaslav Nijinsky, 'The Doctors Don't Believe Me', in James Fadiman and Donald Kewman, eds., Exploring Madness: Experience, Theory, and Research, Brooks/Cole, Monterey, Calif., 1973, pp. 54-60.

³³ Sue Williams, 'Whistleblowers sacked as 'mad'', Sun-Herald, Sydney, 21 September, 1997, p. 23.

³⁴ Benjamin M. Braginsky, Dorothea D. Braginsky and Kenneth Ring, 'The Search for a New Paradigm', in James Fadiman and Donald Kewman, eds., Exploring Madness: Experience, Theory, and Research, Brooks/Cole, Monterey, Calif., 1973, pp. 69-76.

schizophrenic. A person who receives this script is thenceforth compelled by social expectations to rigidly adhere to it. This scripting of the schizophrenic role by diagnosis is often referred to as ‘labelling’.³⁵

Sub-Type 1: Schizophrenic-as-Cultural-Outsider

In considering the question of whether schizophrenics are actually normal in terms of their intrinsic humanity, and are only outsiders because they are abnormal in relation to cultural standards, it might be useful to look again at some of the main indicators of the condition in the light of the M-M-I arguments. DSM-IV specifies these indicators as being positive symptoms like delusions, hallucinations, disorganised speech, and disorganised or catatonic behaviour;³⁶ and/or negative symptoms like affective flattening, alogia and avolition.³⁷ These are the Criterion A symptoms³⁸ and if any one ‘bizarre’ example of these symptoms, or any two examples if they are non-bizarre, correlate with a Criterion B symptom³⁹ — i.e. a social/occupational dysfunction concerning matters like work, interpersonal relations or self-care — then a diagnosis of schizophrenia can be made. It should be pointed out once again that there are no laboratory tests available to confirm a diagnosis and nothing more needs to be done to make a definitive diagnosis than to follow the DSM-IV (or ICD-10)⁴⁰ guidelines.

Let us begin with delusions. In its Glossary of Technical Terms DSM-IV describes a delusion as:

A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person’s culture or subculture (e.g., it is not an article of religious faith).⁴¹

A delusion is said to have the additional pathology of ‘bizarre’ attached to it when it “involves a phenomenon that the person’s culture would regard as totally implausible”.⁴²

The first thing that is evident here is that there is no substantial difference between bizarre and non-bizarre delusions and what seems to differentiate a delusion from a false belief is simply a matter of

³⁵ See for example, Thomas Scheff, Labelling Madness, Prentice-Hall, Englewood Cliffs, N.J., 1975.

³⁶ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV), American Psychiatric Association, Washington, 1994, p. 274-277.

³⁷ Ibid., p. 277.

³⁸ Ibid., p. 285.

³⁹ Ibid.

⁴⁰ World Health Organisation, The ICD-10 Classification of Mental Disorders and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines, World Health Organisation, Geneva, 1992.

⁴¹ American Psychiatric Association, op.cit., p. 765.

⁴² Ibid.

cultural acceptance. This distinction between a false belief and a delusion, by cross-checking for cultural acceptance, is a special psychiatric interpretation of the word ‘delusion’.⁴³ In normal lay usage a ‘delusion’ can be any kind of false belief whether it is accepted by the person’s culture or not.⁴⁴

There are two interesting implications that can be drawn from this DSM-IV definition of delusion. Both concern the beliefs of the psychiatrists who have compiled the manual. The first is that culturally-based beliefs can be false. The second is that, although the compilers believe that religious beliefs can be false beliefs, religious beliefs are not delusions so long as they are culturally-based.

If normal people and schizophrenics both have false beliefs, with the only difference between them being that the normal peoples’ beliefs are culturally acceptable, while those of schizophrenics are culturally unacceptable, then it is hard to avoid the conclusion that the use of delusions as a symptom supports the argument that schizophrenics are no more than cultural outsiders. The requirement to correlate delusions with a disturbance in social functioning (Criterion B) only strengthens this line of thinking.

The DSM-IV Glossary of Technical Terms also defines hallucinations, which is the second Criterion A symptom.

hallucination A sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ. Hallucinations should be distinguished from *illusions*, in which an actual external stimulus is misperceived or misinterpreted. The person may or may not have insight into the fact that he or she is having a hallucination. One person with auditory hallucinations may recognise that he or she is having a false sensory experience, whereas another may be convinced that the source of the sensory experience has an independent physical reality. The term *hallucination* is not ordinarily applied to the false perceptions that occur during dreaming, while falling asleep (*hypnagogic*), or when awakening (*hypnopompic*). Transient hallucinatory experiences may occur in people without a mental disorder.

Types of hallucinations include

auditory A hallucination involving the perception of sound, most commonly of voices. Some clinicians and investigators would not include those experiences perceived as

⁴³ R. W. Butler and D. L. Braff, ‘Delusions: A Review and Integration’, *Schizophrenia Bulletin*, Vol. 17, No. 4, 1991, 633-647.

⁴⁴ See for example, Virginia S. Thatcher, ed., *The New Webster Encyclopedic Dictionary of The English Language*, Consolidated Book Publishers, Chicago, 1970, p. 227.

coming from inside that head and would instead limit the concept of true auditory hallucinations to those sounds whose source is perceived as being external. However, as used in DSM-IV, no distinction is made as to whether the source of the voices is perceived as being inside or outside the head.

gustatory A hallucination involving the perception of taste (usually unpleasant).⁴⁵

The list of hallucination sub-types further extends to include; mood-congruent, mood incongruent, olfactory, somatic, tactile, and visual hallucination. It is significant that the above definition of ‘hallucination’ specifies that “[t]ransient hallucinatory experiences may occur in people without a mental disorder”. This means that hallucinations, in themselves, are not necessarily indicative of abnormality.

To be an indicator of schizophrenia a hallucinatory experience must be beyond the range of normal experience.⁴⁶ Certainly it must be more unusual than the common experience where a person who is distracted, or who is in a noisy environment, imagines the voice of an accompanying person and asks, “did you say something?” When this happens there is usually no suspicion that it might be a symptom of mental disorder.

Exactly how different and unusual a hallucinatory experience has to be to qualify as a symptom of schizophrenia is not specified.⁴⁷ But it is implied by the diagnostic criteria that the “did you say something?” type of hallucination, although seemingly harmless to lay people, might be close to a schizophrenic marker. The observation in the DSM-IV quotation above that some clinicians are only interested in hallucinations of external voices, and ignore those perceived as being inside the head, clearly suggests that the “did you say something?” kind of hallucination, being concerned with an imagined external source, is of the more serious kind.

In its diagnostic overview of schizophrenia DSM-IV specifies that of all the types of hallucination possible, auditory hallucinations experienced as voices “are by far the most common and characteristic of Schizophrenia”⁴⁸. This is repeatedly confirmed in the psychiatric literature.⁴⁹ So it seems that imagined external voices are the most positive of the hallucinatory indicators for schizophrenia, even though these are demonstrably common experiences.

⁴⁵ American Psychiatric Association, *op.cit.*, p. 767.

⁴⁶ N. A. Rector and M. V. Seeman, ‘Auditory Hallucinations in Women and Men’, *Schizophrenia Research*, Vol. 7, No. 3, 1992, pp. 233-236.

⁴⁷ For a discussion on the use of a scale of assessment for evaluating hallucinations see, J. de Leon, M. J. Cuesta and V. Peralta, ‘Delusions and Hallucinations in Schizophrenic Patients’, *Psychopathology*, Vol. 26, Nos. 5 and 6, 1993, pp. 286-291.

⁴⁸ American Psychiatric Association, *op.cit.*, p. 275.

⁴⁹ See for example, P. Chadwick and M. Birchwood, ‘The Omnipotence of Voices: A Cognitive Approach to Auditory Hallucination’, *British Journal of Psychiatry*, Vol. 164, No. 2, 1994, pp. 190-201.

This lack of positive distinction between the normal and the pathological tends to shift the diagnostic emphasis in regard to hallucinations onto the cross-referencing criterion of social/occupational dysfunction. In other words hallucinations alone might not properly distinguish a schizophrenic from a normal person⁵⁰ but if a person is observed to hallucinate, and also to have a disturbance in their social functioning,⁵¹ then the hallucination might indicate schizophrenia. When the diagnostic criteria are interpreted this way it would seem that social functioning is exposed as a key determinant of schizophrenia⁵² and so there is some evidence supporting the schizophrenia-as-outsider argument.

The third symptom in the DSM-IV Criterion A for schizophrenia is disorganised speech. Examples of disorganised speech are given as being ‘derailment’ or ‘incoherence’.⁵³ In the discussion about these symptoms the manual makes it clear that disorganised speech is used as an indicator for an underlying disorganisation in the person’s thinking “because in a clinical setting inferences about thought are based primarily on the individual’s speech.”⁵⁴ This means that for diagnostic purposes the level of organisation apparent in a person’s speech is assumed to represent their level of mental organisation as well.⁵⁵

However, having specified that speech is only meant to be an indicator of a person’s mental state, in a further discussion about varieties of disorganised speech to watch out for, the manual goes on to advise that “[b]ecause mildly disorganised speech is common and nonspecific, the symptom must be severe enough to substantially impair effective communication”.⁵⁶ This means that the compilers of the manual recognise that normal people can have mildly disorganised thoughts, as is sometimes indicated by their speech, and that, in relation to this symptom, the threshold of mental illness is only crossed when a person’s mind is so disorganised that the ability to communicate through speech is impaired.

⁵⁰ N. M. Docherty, W. H. Sledge and B. E. Wexler, ‘Affective Reactivity of Language in Stable Schizophrenic Outpatients and Their Parents’, Journal of Nervous and Mental Disease, Vol. 182, No. 6, 1994, pp. 313-318.

⁵¹ L. A. Opler, C. L. Caton, P. Shrout, B. Dominguez and F. I. Kass, ‘Symptom Profiles and Homelessness in Schizophrenia’, Journal of Nervous and Mental Disease, Vol. 182, No. 3, 1994, pp. 174-178.

⁵² G. Thornicroft, G. Bisoffi, D. De Salvia and M. Tansella, ‘Urban-Rural Differences in the Associations Between Social Deprivation and Psychiatric Service, Utilisation in Schizophrenia and all Diagnoses: A Case-Register Study in Northern Italy’, Psychological Medicine, Vol. 23, No. 2, 1993, pp. 487-496.

⁵³ For a discussion on a method of assessing deviant verbalisations characteristic of schizophrenia see, F. Leichsenring, ‘Discriminating Schizophrenics from Borderline Patients: Study with the Holtzman Inkblot Technique’, Psychopathology, Vol. 24, No. 4, 1991, pp. 225-231.

⁵⁴ American Psychiatric Association, op.cit., p. 276.

⁵⁵ H. A. Allen, P. F. Liddle and C. D. Frith, ‘Negative Features, Retrieval Processes and Verbal Fluency in Schizophrenia’, British Journal of Psychiatry, Vol. 163, 1993, 769-775.

⁵⁶ American Psychiatric Association, op.cit., p. 276.

In using this particular indicator to identify schizophrenia it is the inability to communicate effectively with other people that is the key.⁵⁷ Yet if a person can be diagnosed with schizophrenia simply because his or her speech has been judged in a diagnostic situation to be too disorganised to communicate effectively,⁵⁸ and this has been combined with a perception that the person is also socially or occupationally dysfunctional (Criterion B) — which may be for the same or perhaps some other reason — then this would seem to provide particularly strong evidence that schizophrenia can be culturally determined.

A person who is diagnosed with schizophrenia in this way might simply lack sufficient interest in other people, or perhaps lack the social skills, to easily make themselves understood by others, and as a result has social/occupational difficulties. It is conceivable that the mental functioning of this person might otherwise be quite normal.

Nor does it follow that an impairment in communication necessarily indicates a short-coming in the person who is doing the speaking. In a clinical setting the inability of the diagnostician to understand the patient should perhaps be also taken into account. The essential feature of this particular diagnostic tool is one where the ability of the diagnostician to comprehend the speech of the patient is assumed to be a standard test of sanity. But this begs the question as to whether diagnosticians' minds are calibrated to make standard measurements in this regard. And, if they are, whether that standard is concerned with the measurement of mind or with cultural adaptation. If the latter is indeed the case then it offers strong support to the view of schizophrenic-as-outsider.

The fourth group of Criterion A symptoms is “grossly disorganised or catatonic behaviour”. The DSM-IV guidelines for recognising these symptoms are the following:

Grossly disorganised behaviour (Criterion A4) may manifest itself in a variety of ways, ranging from childlike silliness to unpredictable agitation. Problems may be noted in any form of goal-directed behaviour, leading to difficulties in performing activities of daily living such as organising meals or maintaining hygiene. The person may appear markedly dishevelled, may dress in an unusual manner (e.g., wearing multiple overcoats, scarves, and gloves on a hot day), or may display clearly inappropriate sexual behaviour (e.g., public masturbation) or unpredictable and untriggered agitation (e.g., shouting or swearing). Care should be taken not to apply this criterion too broadly. Grossly disorganised behaviour must be distinguished from behaviour that is merely

⁵⁷ Nancy M. Docherty, ‘Communication disturbances in schizophrenia and mania’, Journal of the American Medical Association, Vol. 276, No. 1, July 3, 1996, p. 4B.

⁵⁸ For an analysis of why schizophrenic speech is unpredictable see, T. C. Manschreck, B. Maher, M. T. Celada, M. Schneyer, and R. Fernandez, ‘Object Chaining and Thought Disorder in Schizophrenic Speech’, Psychological Medicine, 1991; Vol. 21, No. 2, 1991, pp. 443-446.

aimless or generally unpurposeful and from organised behaviour that is motivated by delusional beliefs. Similarly, a few instances of restless, angry, or agitated behaviour should not be considered to be evidence of Schizophrenia, especially if the motivation is understandable.⁵⁹

Whereas the instructions regarding the previously discussed symptom, disorganised speech, specifically make the point that this symptom is only an external indicator of internal mental disorganisation, there is no similar instruction concerning “grossly disorganised behaviour”. This may be an omission on the part of the manual⁶⁰ or it might mean that disorganised behaviour is not meant to be read as an indicator of a corresponding level of inner mental disorganisation. If the latter is the case then the types of disorganised behaviours listed above are merely some of the things schizophrenics have been observed doing and the behaviours do not directly reflect inner mental activity.⁶¹ This would mean then that the wearing of multiple overcoats, or public masturbation, would have the same kind of relationship to schizophrenia as the wearing of a woollen beanie might have to baldness. Both bald and hirsute people might wear beanies. But when a bald person wears one, baldness can serve as a convenient, though not necessarily correct, explanation for why the beanie is worn.

Similarly, schizophrenia might serve as a convenient explanation for why a person might “dress in an unusual manner”, providing the observer has already been informed that a person is indeed schizophrenic.⁶² But to use unusual dress as a diagnostic indicator of mental disorder seems as doubtful as assuming that any person wearing a beanie is bald.

This symptom seems to be so transparently loaded with cultural bias that it does not really require any argument to prove the schizophrenic-as-outsider case. Even so, it is worth noting that although private masturbation is no longer considered to be either a cause or a symptom of madness, as it once was,⁶³ public masturbation is clearly listed as an indicator of schizophrenia. What makes the difference here, apparently, is whether the setting of the behaviour, rather than the behaviour itself, is culturally acceptable.

⁵⁹ American Psychiatric Association, *op.cit.*, p. 276.

⁶⁰ For a discussion on chaos theory as a method of analysing disorganisation in schizophrenics see, G. B. Schmid, ‘Chaos Theory and Schizophrenia: Elementary Aspects’, *Psychopathology*, Vol. 24, No. 4, 1991, pp. 185-198.

⁶¹ It is interesting to note that some of the examples given in the DSM-IV description, like wearing multiple overcoats in hot weather and public masturbation, only appear in the psychiatric literature as anecdotes and do not appear to have been subjected to any kind of extensive scientific investigation. It is possible that these forms of behaviour might have more to do with homelessness than with schizophrenia.

⁶² Richard E. Gallagher and John Nazarian, ‘A Comprehensive Cognitive-Behavioural/Educational Program for Schizophrenic Patients’, *Bulletin of the Menninger Clinic*, Vol. 59, No. 3, 1995, pp. 357-372.

⁶³ Szasz, *The Manufacture of Madness*, *op.cit.*, p. 213.

Negative Symptoms

The fifth and final group of symptoms in Criterion A are the negative symptoms like affective flattening,⁶⁴ alogia,⁶⁵ and avolition.⁶⁶ As the name suggests the negative symptoms are the opposite of the positive symptoms. Positive symptoms are indicated by forms of deviant behavioural activity and they are meant to disclose a commensurate level of inner mental deviance. Negative symptoms, on the other hand, are descriptions of behavioural inactivity,⁶⁷ or lack of activity, and they are supposed to indicate a commensurate level of inner mental inactivity.⁶⁸ If a person does not speak, or speaks as little as possible, (alogia) it is assumed it is because there is insufficient thinking going on to generate communication.

The observed presence of both positive and negative symptoms for schizophrenia indicates that it is a mental disorder with an extraordinary variety of complications.⁶⁹ A schizophrenic might be a person in a highly active delusional state, conversing incoherently with inner voices, wearing multiple overcoats and masturbating in public or, alternatively, it could also be a person who says, and feels, and does, and presumably thinks, next to nothing. It is important to note at this point that the negative symptoms have equal status as diagnostic criteria to the positive symptoms. This means that a person manifesting negative symptoms⁷⁰ is not thought to be in remission, or in an inactive phase of the disease, but is at the time a full-blown schizophrenic and diagnosable.

This range of symptoms is one of the elements that makes schizophrenia so enigmatic, and which makes scientific research into the condition so problematic. Medical model researchers have so far been unable to uncover an underlying common denominator amongst schizophrenics.⁷¹ This is not surprising when the types of people presented to them as subjects are so variable because of the range from negative to positive in the diagnostic criteria. Indeed, much doubt abounds amongst

⁶⁴ R. H. Dworkin, B. A. Cornblatt, R. Friedmann, L. M. Kaplansky, J. A. Lewis, A. Rinaldi, C. Shilliday, and L. Erlenmeyer-Kimling, 'Childhood Precursors of Affective Versus Social Deficits in Adolescents at Risk for Schizophrenia', *Schizophrenia Bulletin*, Vol. 19, No. 3, 1993, pp. 563-577.

⁶⁵ D. D. Miller, S. Arndt, and N. C. Andreasen, 'Alogia, Attentional Impairment, and Inappropriate Affect: Their Status in the Dimensions of Schizophrenia', *Comprehensive Psychiatry*, Vol. 34, No. 4, 1993, pp. 221-226.

⁶⁶ S. Oke, R. Saatchi, E. Allen, N. R. Hudson, and B. W. Jervis, 'The Contingent Negative Variation in Positive and Negative Types of Schizophrenia', *American Journal of Psychiatry*, Vol. 151, No. 3, 1994, pp. 432-433.

⁶⁷ K. T. Mueser, M. S. Douglas, A. S. Bellack, and R. L. Morrison, 'Assessment of Enduring Deficit and Negative Symptoms Subtypes in Schizophrenia', *Schizophrenia Bulletin*, Vol. 17, No. 4, 1991, pp. 565-582.

⁶⁸ W. S. Fenton, and T. H. McGlashan, "Natural History of Schizophrenia Subtypes: Positive and Negative Symptoms and Long-Term Course", *Archives of General Psychiatry*, Vol. 48, No. 11, 1991, pp. 978-986.

⁶⁹ R. C. Bell, L. H. Low, H. J. Jackson, P. L. Dudgeon, D. L. Copolov, and B. S. Singh, 'Latent Trait Modelling of Symptoms of Schizophrenia', *Psychological Medicine*, Vol. 24, No. 2, 1994, pp. 335-345.

⁷⁰ J. P. Selten, N. E. Sijben, R. J. van den Bosch, J. Omlou-Visser, and H. Warmerdam, 'The Subjective Experience of Negative Symptoms: A Self-Rating Scale', *Comprehensive Psychiatry*, Vol. 34, No. 3, 1993, pp. 192-197.

⁷¹ Anon., 'Imaging clues to schizophrenia', *Science News*, Vol. 146, No. 18, Oct 29, 1994, p. 284.

psychiatric researchers as to whether schizophrenics are in fact all of a single type: “Although the symptoms resemble various neurological disorders in various ways, its organic basis remains uncertain. There might be a single underlying process or several processes leading to similar results; some experts prefer to speak of ‘the schizophrenias’ instead of ‘schizophrenia’.”⁷² These doubts, however, do not arise with the schizophrenic-as-cultural-outsider perspective and the use of negative symptoms for diagnosis only makes this argument easier.

Bearing in mind the diagnostic setting, which from the schizophrenic-as-cultural-outsider point of view is a kind of interrogation session in which all power is transferred to the diagnostician,⁷³ it is worth considering the DSM-IV definition of alogia, which is one of the principle negative symptoms:

alogia An impoverishment in thinking that is inferred from observing speech and language behaviour. There may be brief and concrete replies to questions and restrictions in the amount of spontaneous speech (poverty of speech). Sometimes the speech is adequate in amount but conveys little information because it is overconcrete, over-abstract, repetitive, or stereotyped (poverty of content).⁷⁴

“Concrete” is a key term and it is used here to describe “poverty” in both the quantity and quality of speech. In psychiatric literature concrete is used variously to describe the opposite of metaphorical thinking and speech,⁷⁵ as well as to describe the opposite of abstract thinking and speech.⁷⁶ The inclusion of both extremes, overconcrete and over-abstract, in the above definition, indicates that mentally healthy people stick to the middle ground.

Yet even though concreteness is viewed by psychiatric diagnosticians as indicative of schizophrenia in their patients, strangely, it is also viewed as being a quality that therapists should develop in themselves, for working with schizophrenics:

The development of a therapeutic relationship is critically important in work with persons with schizophrenia (Frank & Gunderson, 1990; Lamb, 1982). Core skills of

⁷² Anon., ‘Schizophrenia update’, Harvard Mental Health Letter, Vol. 11, No. 12, June 1995, pp. 1-5.

⁷³ Thomas Szasz, ‘Psychiatric diagnosis, psychiatric power and psychiatric abuse’, Journal of Medical Ethics, Vol. 20, No. 3, 1994, pp. 135-138,

⁷⁴ American Psychiatric Association, op.cit., p. 764.

⁷⁵ M. Spitze, M. Lukas, S. Maier and L. Hermle, ‘Comprehension of metaphoric speech by healthy probands and schizophrenic patients: An experimental psychopathologic contribution to concretism’, Nervenarzt, Vol. 65, No. 5, May 1994, pp. 282-92.

⁷⁶ P. W. Corrigan, R. Silverman, J. Stephenson, J. Nugent-Hirschbeck and B. J. Buican, ‘Situational familiarity and feature recognition in schizophrenia’, Schizophrenia Bulletin, Vol. 22, No. 1, 1996, pp. 153-161.

empathic attunement, warmth, genuineness, and concreteness were used to establish a supportive relationship (Anthony, 1980; Elson, 1986; Hepworth & Larsen, 1993).⁷⁷

What can this contrariness mean? Why is concreteness associated with qualities like “empathic attunement, warmth, genuineness” when it is found in the therapists of schizophrenics, and with a pathological impoverishment of thinking when it is found in the schizophrenics themselves? Can there be anything wrong with concreteness if it is actually recommended as a therapeutic tool? Or, does a therapist who deliberately develops concreteness in speech for therapeutic purposes also run the risk of being diagnosed with schizophrenia?

Perhaps it could be seen as a demonstration of overconcrete thinking to question, in this way, the words used to describe schizophrenic symptoms. But within the M-M-I model there is assumed to be nothing more to schizophrenia than the supposed symptoms themselves.⁷⁸ This means that the words which describe the symptoms are all important because from this perspective it is only a linguistic consensus⁷⁹ amongst psychiatrists that brings schizophrenia into existence. If that linguistic consensus fails, then the current epidemic of schizophrenia could conceivably dissipate.

Quite frequently people are involuntary participants in the clinical procedures that lead to a diagnosis of schizophrenia.⁸⁰ When considered from this perspective psychiatrists can be seen as interrogators who have been retained by a third party to ask probing questions about the person’s private thoughts and beliefs, for the transparent purpose of acquiring damaging evidence.⁸¹ Under these circumstances it might not be surprising if a perceptive and wary person seems concrete in their responses, and gives other evidence of DSM-IV negative symptoms like “brief, laconic, empty replies”.⁸² In fact, when schizophrenia diagnosis is viewed from the schizophrenic-as-outsider angle, the specification of negative symptoms like these appear to be no more than a ‘Catch-22’ — anything the person says about themselves can be used against them, and if nothing of substance is said, that can be used too.

Avolition is another of the negative symptoms:

⁷⁷ William Bradshaw, ‘Evaluating Cognitive-Behavioural Treatment of Schizophrenia: Four Single-Case Studies’, *Research on Social Work Practice*, Vol. 7, No. 4, October, 1997, p. 419.

⁷⁸ For a discussion on the practice of interpreting signs as pathological indicators in the absence of diseases see, Thomas Szasz, ‘Diagnoses are not diseases’, *op.cit.*, pp. 1574-1577.

⁷⁹ N. C. Andreasen, and W. T. Carpenter Jr, ‘Diagnosis and Classification of Schizophrenia’, *Schizophrenia Bulletin*, Vol. 19, No. 2, 1993, pp. 199-214.

⁸⁰ Thomas Szasz, ‘The Case Against Psychiatric Coercion’, *The Independent Review*, Vol. I, No. 4, Spring 1997, pp. 1086-1653.

⁸¹ Lara Jefferson, ‘I Have Kept a Lone Death Watch with Madness When Reason Was Dying’, in James Fadiman and Donald Kewman, eds., *Exploring Madness: Experience, Theory, and Research*, Brooks/Cole, Monterey, Calif., 1973, pp. 14-23.

⁸² American Psychiatric Association, *op.cit.*, p. 276.

avolition An inability to initiate and persist in goal-directed activities. When severe enough to be considered pathological, avolition is pervasive and prevents the person from completing many different types of activities (e.g., work, intellectual pursuits, self care).⁸³

Consider a person who does not share with other people an appropriate level of culturally-acquired goal-direction for specific activities like formal education and career.⁸⁴ This kind of person is often referred to as a loser, a drop-out, a bum, a hopeless case, or a never-do-well. The specification of avolition as a symptom makes it apparent that 'schizophrenic' can also be added to this list of pejoratives.

In discussing the negative symptoms DSM-IV warns: “Although quite ubiquitous in Schizophrenia, negative symptoms are difficult to evaluate because they occur on a continuum with normality”. But this “continuum with normality” is exactly what the schizophrenic-as-outsider model argues. Alogia might be no more than a disinclination for conversation in situations where such a disinclination is culturally unacceptable.⁸⁵ Similarly, avolition might be no more than a disinclination to participate in normal social intercourse.⁸⁶ If these disinclinations are indeed on a continuum with normality, then in relation to the negative symptoms at least, the schizophrenic-as-outsider case is very strong.

Criterion B is the second group of diagnostic indicators which are concerned with social or occupational dysfunction in the areas of interpersonal relations, work or education, or self-care. If Criterion A symptoms have been identified the diagnostician cross-checks to see whether there is any evidence of social or occupational dysfunction:

Typically, functioning is clearly below that which had been achieved before the onset of symptoms. If the disturbance begins in childhood or adolescence, however, there may

⁸³ *Ibid.*, p. 764.

⁸⁴ For a discussion on establishment concerns about a perceived general decline of the work ethic in the United States see, Chuck Colson and Jack Eckerd, *Why America Doesn't Work*, Word Publishing, Dallas, 1991.

⁸⁵ For an insight into the way rating scales are used to identify this symptom see, R. H. Dworkin, G. Bernstein, L. M. Kaplansky, J. D. Lipsitz, A. Rinaldi, S. L. Slater, B. A. Cornblatt, and L. Erlenmeyer-Kimling, 'Social Competence and Positive and Negative Symptoms: A Longitudinal Study of Children and Adolescents at Risk for Schizophrenia and Affective Disorder', *American Journal of Psychiatry*, Vol. 148, No. 9, 1991, pp. 1182-1188.

⁸⁶ For a demonstration of how psychiatrists deal with patients who dispute with them on this matter, by claiming they lack insight, see, J. P. McEvoy, N. R. Schooler, E. Friedman, S. Steingard, and M. Allen, 'Use of Psychopathology Vignettes by Patients with Schizophrenia or Schizoaffective Disorder and by Mental Health Professionals to Judge Patient's Insight', *American Journal of Psychiatry*, Vol. 150, No. 11, 1993, pp. 1649-1653.

be failure to achieve what would have been expected for the individual rather than a deterioration in functioning. Comparing the individual with unaffected siblings may be helpful in making this determination. Educational progress is frequently disrupted, and the individual may be unable to finish school. Many individuals are unable to hold a job for sustained periods of time and are employed at a lower level than their parents (“downward drift”). The majority (60%-70%) of individuals with schizophrenia do not marry, and most have relatively limited social contacts.⁸⁷

There seems to be some overlap here with avolition. A loss of interest in activities of social value, or a loss of interest in climbing the ladder of social status, or even failure to satisfy the status expectations of others, are all deemed to be indications of mental pathology. Ostensibly Criterion B indicators are used as a cross-reference to evaluate the level of disability a person incurs from the presence of one or more Criterion A symptoms. As such it might not be expected they would be used as symptoms themselves. That is, occupational dysfunction, as it relates to Criterion B, is only significant as a measure of the detrimental effect of a Criteria A symptom like delusions. A delusional person is not schizophrenic if a cross-check finds there is no interference with his or her social or occupational functioning.

If the corollary is true, i.e. that, for instance, an occupationally dysfunctional (unemployed) person is not schizophrenic in the absence of Criterion A symptoms, then there is not much of a case to make for the schizophrenic-as-cultural-outsider out of Criterion B indicators. This is despite the fact that these indicators are concerned with failure in normal social activities — and to interpret such failure as a sign of pathology would be clear evidence of the schizophrenic-as-cultural-outsider.

However, although Criterion B indicators are supposedly only intended to give secondary confirmation of pathology, by way of a cross-check for social and occupational incompetence, references can be found in the literature of mental health professionals arguing that “[i]mpairment in the ability to work is a defining characteristic of schizophrenia”.⁸⁸ Thomas Szasz has written emphatically about the way occupational dysfunction in young people can lead to a diagnosis of schizophrenia.⁸⁹

Further DSM-IV diagnostic instructions in Criterion C give advice that confirms Criterion B symptoms might sometimes be used as primary indicators of schizophrenia. Criterion C defines schizophrenia by the length of time that Criterion A and B indicators have been present:

⁸⁷ American Psychiatric Association, *op.cit.*, p. 278.

⁸⁸ Paul Lysaker and Morris Bell, ‘Work Performance Over Time for People With Schizophrenia’, *Psychosocial Rehabilitation Journal*, Vol. 18, No. 3, 1995, pp. 141-146.

⁸⁹ Thomas Szasz, *Cruel Compassion: Psychiatric Control of Society’s Unwanted* John Wiley and Sons, New York, 1994, p. 145.

C. *Duration*: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).⁹⁰

What is apparent here is that Criterion B indicators can be used as the primary symptoms while Criterion A indicators can be used as the secondary symptoms. If, for instance, a person has been occupationally dysfunctional i.e. unemployed (Criterion B) for six months prior to a diagnostic encounter, and over that period had stopped looking for work for at least a month (Criterion A5, avolition), then all that is required to fix the person with a label of schizophrenia is one other Criterion A indicator that was also present for one month out of the previous six months. An obvious example that might confirm the schizophrenic-as-cultural-outsider picture, given the financial circumstances of unemployment, would be a dishevelled appearance, or unusual dress (Criterion A4).

It is clear from an examination of these three sets of DSM-IV diagnostic criteria that it is not necessary for a person to have an abnormally functioning mind in order to be diagnosed with schizophrenia. Theoretically, it is quite obvious that people can be diagnosed, even though their thinking and behaviour might be on a continuum with that of normal people, simply because a psychiatrist observes personal attributes that are outside the boundary of cultural acceptance.⁹¹

Outsider Case Studies

There are numerous case studies in the literature of psychiatric survivors that confirm this contention. A particularly compelling story of this kind about personal diagnosis and treatment for schizophrenia is told by Leonard Roy Frank in an interview with Seth Farber. Frank is the author of a number of articles⁹² and books⁹³ which argue against coercive psychiatry and particular psychiatric practices.

⁹⁰ American Psychiatric Association, *op.cit.*, p. 285.

⁹¹ For an example of how some psychiatrists are campaigning to link homelessness with schizophrenia see, E. Fuller Torrey, 'Stop the Madness', *The Wall Street Journal*, 18 July, 1997.

⁹² Leonard Roy Frank, 'Electroshock: Death, Brain Damage, Memory Loss, and Brainwashing', *The Journal of Mind and Behavior*, Vol. 11, Nos. 3 and 4, 1990, pp. 489-512.

⁹³ Leonard Roy Frank, ed., *The History of Shock Treatment*, Leonard Roy Frank, San Francisco, 1978.

In the interview with Farber, Frank recounts how he began a promising career in real estate sales in Florida and San Francisco. At a certain point, however, he decided to quit his job and take some time off to read books and follow an interest in philosophy. When his parents heard about his new life-style they went to visit him and, dismayed at his lack of interest in continuing his career in real estate, they advised him to see a psychiatrist. When he refused they signed the necessary papers to have him involuntarily committed to a mental hospital. He was diagnosed with paranoid schizophrenia and given 85 shock treatments. When he finally obtained his psychiatric records 12 years later he discovered the symptoms that had been identified to justify the diagnosis and treatment included: “not working, withdrawal, growing a beard, becoming a vegetarian, ‘bizarre behaviour’, ‘negativism’, ‘strong beliefs’, ‘piecing eyes’, and ‘religious preoccupations’. The medical examiner’s initial report said that I was living the ‘life of a beatnik — to a certain extent’.”⁹⁴

But testimonials about personal experience like this from people who have been diagnosed with schizophrenia, and who say there was actually nothing wrong with them, do not carry much weight with either the psychiatric profession⁹⁵ or the public in general. This is because any person who has ever been diagnosed with schizophrenia is generally assumed to only have, at best, a tenuous grip on reality. This means that anything such a person says about themselves or their experiences can easily be, and often is, dismissed as delusions.

In the long run the case for the schizophrenic-as-outsider largely rests on evidence supplied by sources which support mainstream psychiatry. The schizophrenic-as-outsider argument is best made as a re-interpretation of the many descriptions of schizophrenia and schizophrenics that appear in the mainstream psychiatric literature.⁹⁶ A good example of the sort of description that can be subjected to this type of re-interpretation can be found in the 1996 Annual Report of the NSW Mental Health Review Tribunal.

The Mental Health Review Tribunal is constituted under the NSW Mental Health Act to make determinations in individual cases about psychiatric treatment, the continuation of prolonged commitment and the issuing of community treatment orders. The Tribunal appears to be conducting a campaign to extend the net of psychiatric coercion by using an assortment of arguments. One argument is that the criteria of mental illness for involuntary treatment should be expanded beyond psychosis to include DSM-IV prescribed Personality Disorders “because mental illnesses and

⁹⁴ Leonard Roy Frank, Interview, in Seth Farber, Madness Heresy, and the Rumor of Angels: The Revolt Against the Mental Health System, op.cit., p. 193.

⁹⁵ M. J. Cuesta, and V. Peralta, ‘Lack of Insight in Schizophrenia’, Schizophrenia Bulletin, Vol. 20, No. 2, 1994, pp. 359-366.

⁹⁶ See for example, J. M. Eagles, ‘The Relationship Between Schizophrenia and Immigration. Are There Alternatives to the Psychosocial Hypotheses?’, British Journal of Psychiatry, Vol. 159, 1991, pp. 783-789.

personality disorders both probably have a genetic component”.⁹⁷ Another of the Tribunal’s arguments is that homeless people, who are thought to be diagnosable with schizophrenia, should be forced into treatment. A fictitious case study is given of a generic homeless man called Max who illustrates the type of person the Tribunal wants to incarcerate:

Max is a homeless middle-aged resident of the streets of Central Sydney. He drops in daily to an inner city hostel, for a meal, and very occasionally, a wash. Max never showers. He never changes his clothes. He is dressed permanently in an incongruous outfit, far too hot for the summer months, loaded up, in its numerous pockets and cavities, with pens, and scraps of writing paper. Max has, for as long as the hostel workers have known him, suffered from the delusion that he is a high-powered corporate lawyer, working with the banks to protect corporate Australia from incursions of the Mafia. If the Mental Health Act 1990 could be brought to bear in Max’s case, he could be hospitalised for a period and his delusion addressed through psychotropic medication. A protected estates order could be obtained, so that an application could be made on Max’s behalf for a social security benefit. He could be required under a community treatment order, to live in public housing, with the rent being paid on his behalf, out of the Social Security Benefit, which could be sought on his behalf, by the protective Commissioner. Max’s life could, in other words, be taken over by a group of public officials, and mental health professionals, and he could, with the assistance of medication, be re-made. But Max literally runs very quickly in the other direction if anyone, particularly a lawyer, approaches him with an offer of help.

The Tribunal goes on:

The current definition of “mentally ill person” for the purposes of civil commitment under the Mental Health Act 1990 could conceivably be interpreted to cover Max. But, if recent media publicity is true, threatened cutbacks in services for the homeless inner city mentally ill might mean that there would be no bed for Max even if the police could be persuaded to pick him up off the street take him to a psychiatric unit for assessment.⁹⁸

In describing Max in this way, as an example of the type of supposedly schizophrenic person who is currently slipping through the net of coercive psychiatry, the Tribunal is apparently targeting homelessness as an area in need of attention. Homeless people are certainly cultural outsiders, and a

⁹⁷ Mental Health Review Tribunal, Annual Report 1996, NSW Government, p. 15.

⁹⁸ Ibid., p. 55.

close association is claimed in psychiatric literature between homelessness and schizophrenia: “an estimated 33%-50% of homeless Americans are schizophrenic”.⁹⁹

However, it is not always easy to establish whether homeless people are thought to be schizophrenic because of their homelessness, or alternatively, whether schizophrenics are thought to become homeless because of their mental disorganisation:

They generally refuse to have contact with the authorities or those who can provide treatment. They experience delusions, deep anxiety and considerable suffering. And even though there are exceptions, they are usually homeless - at least to the extent that they do not feel that they belong to the community in which they live. They have a miserable life, as social outcasts.¹⁰⁰

Certainly the Tribunal seems to be as much concerned about getting treatment for Max’s Criteria B symptom of homelessness, by arranging accommodation for him, as it is to get his Criteria A delusions treated with medication.

Sub-type 2: Schizophrenic-as-Scapegoat

Acting as scapegoat for a group appears to be a role some schizophrenics are repeatedly forced to play. In psychotherapeutic situations, where schizophrenics are placed into heterogeneous groups containing patients who are not schizophrenic, it has been observed that the schizophrenics readily become the scapegoats for the group:

the schizophrenic being the prime candidate in the group for the role of the scapegoat ... other members can deny their fears of intimacy and project them on to the scapegoat. The scapegoat acts as a safety valve that protects the group from the imagined dangers of closeness. Shifting attention away from the scapegoat can reduce his or her anxiety.¹⁰¹

From the schizophrenic-as-scapegoat angle, if a schizophrenic is observed, after diagnosis, to fill the role of scapegoat in a psychotherapeutic group of non-schizophrenics, it is only because, prior to diagnosis, the schizophrenic had already learned to play that role in another over-stressed group

⁹⁹ Anon., ‘Schizophrenia and the D2, 5-HT2 receptors: maximizing drug efficacy’, Medical Sciences Bulletin, Vol. 19., No. 3, 1996, p. 8.

¹⁰⁰ Phillip W. Long, ‘Schizophrenia and Homelessness: Our demand for efficiency will turn the hardest hit into outcasts’, Prelapse Magazine, No. 2, September 1995.

¹⁰¹ Alan R. Beeber, ‘Psychotherapy with Schizophrenics in Team Groups: A Systems Model’, American Journal of Psychotherapy, Vol. 45, No. 1, 1991, pp. 78-87.

with similar problems.¹⁰² From the schizophrenic-as-scapegoat perspective, the ability to fill the role of scapegoat for a therapeutic group demonstrates the single essential feature of schizophrenia. The diagnostic criteria discussed in the previous section are largely irrelevant from this perspective and any alleged distinguishing indicators, like delusions and hallucinations, are only artefacts of imagination manufactured by members of the over-stressed group and/or the diagnostician.¹⁰³

The over-stressed group from which the schizophrenic/scapegoat has come before diagnosis is most commonly a nuclear family, but groups and organisations of other types also sometimes need scapegoats too: “the scape-goat selector — whether inquisitor or psychiatrist — does not work in a social vacuum. The persecution of a minority group is not imposed on a resistant population, but, on the contrary, grows out of bitter social conflicts.”¹⁰⁴

In the Manufacture of Madness Thomas Szasz undertakes the definitive analysis of the schizophrenic-as-scapegoat. Psychiatric historians normally assert that witches who fell victim to the Inquisition were mentally ill people who were victimised on account of their mental illness.¹⁰⁵ Szasz turns this conventional historical understanding on its head. He asserts that modern people diagnosed with mental illness are made scapegoats, in the same way as witches were in earlier times, by falsely labelling them with an imaginary form of deviance:

the basic function of the medical theory of witchcraft — and, in my opinion, its basic immorality as well — lies in distracting from the persecutory practices of the institutional psychiatrists, and focussing it instead on the alleged disorders of the institutionalised mental patients.¹⁰⁶

Szasz argues that the tendency for humans to be social and to always live in groups has a strong influence on shaping human nature.¹⁰⁷ Membership of a group has a price and sometimes members are required to attack non-members as a means of further integrating themselves into the group, and also as a way of adding cohesion to the group itself. Group dynamics can also require that a member be selected for conversion into a non-member for the purpose of being sacrificed. When this happens any members who do not participate in the scapegoating might themselves risk alienation and sacrifice.

¹⁰² See for example, John Modrow, How To Become A Schizophrenic: The Case Against Biological Psychiatry, Appollyon Press, Seattle, 1992.

¹⁰³ Szasz, Schizophrenia: The Sacred Symbol of Psychiatry, op.cit., p. 87.

¹⁰⁴ Szasz, The Manufacture of Madness, op.cit., p. 136.

¹⁰⁵ H. P. Greenberg, ‘Historical Perspectives’, in Pierre J. Beumont and R. B. Hampshire, Textbook of Psychiatry, Blackwell, Melbourne, 1989, p. 19.

¹⁰⁶ Szasz, The Manufacture of Madness, op.cit., pp. 127-128.

¹⁰⁷ Ibid., p. 316.

The explanation for why this happens concerns the need for self-validation. By declaring an enemy, either internal or external, as invalid, and therefore bad, a person by implication declares themselves to be valid and good: “Typically, we confirm our loyalty to our group by asserting the disloyalty of others (in or outside the group) to it; we thus purchase membership in the community by excluding others from it.”¹⁰⁸

Modern people have acquired a habit of attributing sub-human status to classes of people who are selected for scapegoating. This attitude was applied to witches during the Inquisition, Jews in Nazi Germany and regularly happens to people who are ethnically affiliated with the enemy in times of war. Similarly, when family groups find the need to sacrifice a member, a convenient modern method is to declare that the person has a dysfunctional brain.

In European folklore a changeling was a stupid or deformed child who was said to have been secretly changed for another, true child of the family, by fairies. The identification of a changeling was a way of disowning a child by declaring it a non-member of the family. Szasz utilises a powerful changeling-like metaphor by citing a novel written by Jerzy Kosinski called The Painted Bird.¹⁰⁹ In the novel a Polish peasant makes a practice of painting captured birds brilliant colours and then releasing them. After they are released the birds attempt to join others of their own kind but are invariably attacked and killed for being different.

The painted bird is the perfect symbol of the Other, the Stranger, The Scapegoat. With inimitable skill, Kosinski shows us both faces of this phenomenon; if the other is unlike the members of the herd, he is cast out of the group and destroyed: if he is like them, man intervenes and makes him appear different, so that he may be cast out of the group and destroyed. As Lekh paints his raven, so psychiatrists discolour their patients, and society as a whole taints its citizens.¹¹⁰

The schizophrenic-as-scapegoat model is sometimes most readily recognised by people who have themselves been declared schizophrenics. Indeed, the dynamics of selecting and out-casting a scapegoat usually mean that only the victims, or other outsiders of the group, are in a position to consciously observe the process. There are a number of personal accounts of schizophrenia told by people who see themselves as scapegoats. A particularly lucid story is told by John Modrow in How To Become A Schizophrenic.¹¹¹

¹⁰⁸ Ibid.

¹⁰⁹ Jerzy Kosinski, The Painted Bird, Houghton Mifflin, Boston, 1965.

¹¹⁰ Szasz, The Manufacture of Madness, op.cit., p. 321.

¹¹¹ Modrow, op.cit.

Modrow recounts growing up in a family riddled with stress fractures inherited from previous generations. His mother was the daughter of Norwegian immigrants to the United States and, after her father died, had been forced to play the role of surrogate mother to her siblings, while her own mother worked sixteen hours a day.¹¹²

On Modrow's father's side of the family his great-grand mother had died in an insane asylum providing grounds for whispered expectations of a family curse that would surface once again.¹¹³ A story told to Modrow by his sister, who in turn had heard it from his mother shortly before she died, is critical to his story of selection as the family scapegoat. When he was very young his mother and paternal grand mother were chatting in the kitchen while he was sitting outside in the sun, rocking back and forth, absorbed in thought. His mother, seeing him through the door, and thinking he looked cute, smiled and drew her mother-in-law's attention to him. The mother-in-law, however, misunderstood his mother's meaning and angrily jumped to the defence of the child, accusing his mother of mocking him. The result, deduced by Modrow as an adult, was a life-long accusation levelled at Modrow by his mother that he would never let her love him.¹¹⁴

After this incident, when Modrow was six, his mother decided he was in need of a psychiatric examination.¹¹⁵ There was apparently a minor incident involving Modrow and a man in a wheelchair which triggered this unusual course of action but the first psychiatrist he was taken to was so unconcerned about it that he declined to make the examination. When Modrow asked his mother many years later why she thought he needed to be examined she told him it was because, "You would never let me love you" and "Other people made you ill."¹¹⁶ These were two accusations Modrow had been hearing all his life and although the first could be traced to a plausible genesis in the misunderstanding between his mother and grand-mother, the second never made any sense to him and seemed to be something his mother might have made up.¹¹⁷

Six weeks after the first attempt to put a psychiatric label on him Modrow's mother took him to be examined by a psychiatric team at the University of Washington. According to his mother the psychiatrists told her: "We don't know exactly what is wrong with your son, but whatever it is, it is

¹¹² *Ibid.*, p. 31.

¹¹³ *Ibid.*, p. 2.

¹¹⁴ *Ibid.*, p. 34.

¹¹⁵ *Ibid.*, p. 38.

¹¹⁶ *Ibid.*, p. 33.

¹¹⁷ It is possible that "social withdrawal" was a symptom his mother had been warned by psychiatrists to look out for. For a discussion on the symptoms of childhood schizophrenia see, Kenneth E. Towbin, Elisabeth M. Dykens, Geraldine S. Pearson, and Donald J. Cohen, 'Conceptualizing "borderline syndrome of childhood" and "childhood schizophrenia" as a developmental disorder', *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 32, No. 4, July 1993, pp. 775-783.

very serious. We recommend that you have him committed immediately or else he will be completely psychotic within less than a year”.¹¹⁸

His mother did not follow the advice to have him committed at that time but the assumption that he had a serious mental illness became incorporated into his family identity. Although by his own estimation there was nothing wrong with him, he was by degrees schooled into playing the role of the mad member of the family. Modrow’s description is of a family with unusual levels of stress and his supposed difference within this group allowed the other members of the family to contrast themselves with him and thereby assume normal roles. In this way the family maintained outward signs of normality until Modrow was finally hospitalised for schizophrenia as an adolescent.

His stay in hospital was only a short one but it took him another three decades of introspection and family analysis to properly understand what had happened to him. Modrow says he wrote his book because he believes “it is a fact beyond reasonable dispute that I had been victimised by a series of events — not by a disease. And I believe this can be demonstrated to be true of all people who have been labelled schizophrenic.”¹¹⁹

Families are not the only groups in need of scapegoats. Work-places also seem to produce a number of schizophrenics. A story describing the ease with which a person can be involuntarily hospitalised on the report of an employer is told in a volume of personal recollections of patients entitled Inside the Cuckoo’s Nest: Madness in Australia.¹²⁰ The story concerns John Thomas who tells how he went to his place of employment on Christmas eve for the specific purpose of attending a Christmas party. Not long after he arrived,

the Administration Manager approached me and complained of my noisy behaviour — I had shouted hurrah, once, in the board room. A few moments later, the General Manager called me into his office and also began to abuse me about the supposed noise I was making. He told me he would arrange for me to be taken home, because I was sick.¹²¹

Thomas decided to leave the party and to make his own way home. He began to walk but found he was being followed by two of his fellow workers who tried to coax him into taking a lift with them. He refused and took a short-cut through a park, hoping to lose them. When he reached the park exit three police cars suddenly appeared with sirens blaring. He was seized by two officers, held over the boot of a police car, and searched.

¹¹⁸ Modrow, op.cit., p. 1.

¹¹⁹ Ibid., p. 3.

¹²⁰ Jim Gardner, Inside the Cuckoo’s Nest: Madness in Australia, Planet Press, Sydney, 1976.

¹²¹ Ibid., p. 23.

Within a few minutes the General Manager arrived at the scene and spoke to the police officers. A cavalcade of cars then returned to the company offices and one of the policemen went into the building with the General Manager. After ten minutes the policeman re-emerged and, against his protests, Thomas was then transported in the back of a police car to the psychiatric ward of a nearby hospital. He was then involuntarily admitted to the hospital, treated against his will with the neuroleptic drugs Melleril and Largactil, used in front-line treatment for schizophrenia, and for several days was not allowed to make contact with his wife or lawyer. When he finally made contact he was quickly released. This appears to have been the only occasion on which Thomas has been involved in the mental health system and he said of the experience: “This frightening incident has caused me and my family great distress and embarrassment, and I feel it should be brought to public notice and fully investigated.”¹²²

The use of psychiatry in the scapegoating of Thomas by his employers seems to be so blatant that it might not be representative of how other people become schizophrenic scapegoats at places of employment. However, the story has been briefly retold because it demonstrates in a simple way that the psychiatric label of schizophrenia can be used to scapegoat people in the work-place.

A more consistent pattern of scapegoating by using schizophrenia, and other psychiatric labels, is found in cases of whistleblowing.¹²³ A whistleblower is a person who speaks out in the public interest, typically about corruption or some other kind of wrongful practice at a place of work. Whistleblowing is the act of reporting this wrong-doing to the appropriate authority and/or publicly revealing it through the mass media.¹²⁴ There may be numerous reasons for an organisation to avoid acknowledgment of a whistleblower’s message — not the least common being that, unbeknown to the whistleblower, people at upper-levels of the organisation may have given tacit or covert approval for the wrong-doing. Another common reason for resisting a whistleblower is fear that the organisation might be damaged by exposure.

Whistleblowing, therefore, can be a hazardous activity and whistleblowers themselves are usually a little bit out of the ordinary in that they are likely to have elevated levels of personal integrity and courage,¹²⁵ combining with a naive faith in the prevalence of justice. If the organisation chooses to

¹²² *Ibid.*, p. 23.

¹²³ Whistleblowers Australia, Abuse of Medical Assessments to Dismiss Whistleblowers, accessed December 1997, Available URL, <http://www.uow.edu.au/arts/sts/bmartin/dissent/documents/psychiatry.html>

¹²⁴ For a number of stories about whistleblowing activities see, Gerald Vinten, ed., Whistleblowing: subversion or corporate citizenship?, Paul Chapman, London, 1994.

¹²⁵ For the story of a whistleblower who was inappropriately incarcerated in a psychiatric facility and subsequently awarded the Cavallo Prize for Moral Courage in 1995 see, The Cavallo Foundation, Navy Lieutenant Speaks Out Against Sexual Harassment in the Military, CitySource, accessed January 1998, Available URL, <http://www.cavallo.org/simmons.html>

ignore the whistleblower's complaint this combination of personality traits can easily lead the whistleblower into a situation of being forced to doggedly repeat assertions that something is wrong in the organisation. The whistleblower is then perfectly positioned to be a scapegoat for the organisation, to relieve the stress that might have been generated by the attempted revelation.¹²⁶ A favoured tactic is to refer the whistleblower for a psychiatric examination to be carried out by a psychiatrist retained by the organisation.¹²⁷ Even psychiatrists themselves are not immune from this treatment and in one recent case a psychiatrist who blew the whistle on improper activities in mental hospitals in the United States was "fired and labelled impaired".¹²⁸

An example of the use of psychiatry to scapegoat whistleblowers has been documented in a recently-released report by the Commonwealth (Australia) Ombudsman's office. An investigation by the Ombudsman into the harassment of whistleblowers in the Australian Federal Police (AFP) found "four relevant instances since 1992 where the AFP has arranged for officers to undergo inappropriate psychiatric assessments, either under duress, or without their knowledge or consent".¹²⁹

Whistleblowers Australia is currently conducting a survey of their members to discover how many have been treated in this way. The number discovered so far in NSW alone is about thirty.¹³⁰ Most of these people have received psychiatric diagnoses ranging from non-specific conditions like cognitive dysfunction, to personality disorders and schizophrenia.¹³¹ There is a strong conviction amongst the members of Whistleblowers that their referrals for psychiatric assessment are a form of harassment and that an allegation of mental disorder is a tactic used to discredit them and also, frequently, to terminate their employment.¹³²

At least one member of Whistleblowers Australia has lodged a complaint about her harassment with the World Psychiatric Association's Committee to Review the Abuse of Psychiatry. Interestingly, shortly after receiving acknowledgment of the complaint from the Secretary of the Committee in

¹²⁶ For an analysis of various forms of retaliation taken against whistleblowers by a government instrumentality in the United States see, National Academy of Public Administration, Department of Energy Retaliation Complaint Study, accessed January 1998, Available URL, <http://www.accessone.com/gap/www/napa.htm>

¹²⁷ Anon., Whistleblower Protection: Continuing Impediments to Protection of Military Members, Letter Report, 02/02/95, GAO/NSIAD-95-23, accessed January 1998, Available URL, <http://www.natcavoices.org/natca/f/nsiad95-23.htm>

¹²⁸ Fred A. Baughman Jr, 'The future of mental health: radical changes ahead', USA Today, Vol. 125, No. 2622, March 1997, pp. 60-63.

¹²⁹ Commonwealth Ombudsman, AFP professional reporting & internal witnesses, November 1997, p. 53.

¹³⁰ Val Kerrison, Principle organiser of the survey, Personal communication, September, 1998.

¹³¹ Louise Roy, Psychiatry and the Suppression of Dissent, unpublished report on the use of psychiatric labels to intimidate whistleblowers, December 1997.

¹³² Whistleblowers Australia, Healthquest — Unethical, Immoral and Unjust: Misuse of "Psychiatric Findings" to Aid and Abet Employers in Workplace Dismissals, Press Release, 11 December, 1997.

Denmark¹³³ the complainant was asked by her employer to attend another psychiatric examination. The result of this subsequent examination was that she was found to be in perfect mental health.

Sub-Type 3: Schizophrenia-as-Role-Play

Schizophrenia-as-role-play is a branch of the myth-of-mental-illness model which interprets the symptoms of schizophrenia as being simulations of the prescribed patterns of schizophrenic thought and behaviour. These simulations are required of a person in order to fulfil a role that may have been either chosen by the schizophrenic, or imposed by other people. Analysts who argue that such roles are normally chosen by the schizophrenics themselves are inclined to see schizophrenics as predatory, exploitative types of people.¹³⁴ Conversely, those who prefer to see the schizophrenic role as an imposition tend to argue that schizophrenics are victims of labelling who, once diagnosed, are compelled by other people's expectations to behave in the prescribed manner of a schizophrenic.¹³⁵

The evolution of Thomas Szasz's myth-of-mental-illness views has involved a passage through both the schizophrenic-as-cultural-outsider and the schizophrenic-as-scapegoat sub-types. But more recently his attachment to libertarian philosophy¹³⁶ has swung him into the schizophrenia-as-role-play model where he shows a distinct lack of sympathy for people who willingly adopt the role of schizophrenic. In a recent article, descriptively entitled 'Idleness and Lawlessness in the Therapeutic State',¹³⁷ he refers to schizophrenics as parasites. After establishing that modern society is divided between producers and parasites he goes on to argue that people with 'real' illnesses who adopt the sick role are not idle and therefore not parasites. However, "in contrast, most chronic mental patients — especially schizophrenics — are idle, economically dependent, and inclined (allegedly because of their illness) to lawlessness."¹³⁸

Szasz's view is that failure to make the necessary transitions in the process of maturation, from childhood to adolescence to adulthood, is what determines whether a person will become identified as a schizophrenic. If a person successfully passes through the three stages and establishes an adult identity by "being useful to other people",¹³⁹ i.e. having a productive occupation, then the society will accept the person as being in mental health. But "[i]f this process of maturation goes awry, the adolescent begins to envy his peers and to feel inferior to them".¹⁴⁰

¹³³ Hanne Meyn, Secretary to the Committee to Review the Abuse of Psychiatry, World Psychiatric Association, Letter to Louise Roy, 9 January, 1998.

¹³⁴ Szasz, 'Psychiatric Diagnosis, Psychiatric Power and Psychiatric Abuse', op.cit., pp. 135-139.

¹³⁵ Thomas Scheff, 'Schizophrenia as Ideology', in Scheff, ed., Labelling Madness, op.cit., pp. 5-12.

¹³⁶ Roger Neustadter, 'Szasz, Lasch, and Illich on the Problem of the Therapeutic State', Quarterly Journal of Ideology, Vol. 15, Nos. 3-4, 1991-1992, pp. 29-49.

¹³⁷ Szasz, Idleness and Lawlessness in the Therapeutic State, op.cit.

¹³⁸ Ibid., pp. 30-36.

¹³⁹ Ibid.

¹⁴⁰ Ibid.

When this happens, in order to compensate, the person might intentionally develop delusions of self-importance and perhaps begin to express unusual beliefs and mannerisms, as marks of assumed distinguishment. According to Szasz, as such a person slides further away from a normal productive adult identity, family members, teachers and friends tend to indulge the person and offer more leeway. The process of differentiation continues until the person gives some suggestion of potential violence, which might give warning of self-harm, or harm to somebody else.¹⁴¹ At this point the person is likely to be brought into contact with a psychiatrist who will give a diagnosis of schizophrenia.¹⁴² Henceforth the well-known symptoms of schizophrenia provide an easily followed identity-script to guide the person in his or her future social role.

If one begins an analysis from Szasz's viewpoint — i.e. that even before diagnosis a schizophrenic will have developed parasitic tendencies — then the key to the cause of schizophrenic symptoms will most likely be found in the perquisites of mental patient-hood. From this angle it is assumed that some people simulate the symptoms in order to get the family attention,¹⁴³ social welfare payments and special human rights considerations that are usually offered to schizophrenics. Indeed, so great has the cost of supporting people with mental illnesses become in the United States that the myth-of-mental-illness is now even being raised in an economic context:

Not well known is the fact that as of 1994, 57 percent of adults receiving SSI disability payments did so based on a diagnosis of a mental disorder and that federal spending on SSI exceeded federal spending on Aid to Families with Dependent Children by some \$7 billion.¹⁴⁴

The simulation of madness for personal advantage or disguise is not a new idea. It must have been well understood in 16th century England, for instance, because in a number of Shakespeare's plays characters feign madness in order to disguise either their identities or their intentions. Hamlet feigns madness to put his enemies off guard. In King Lear, Edgar adopts the persona of the madman, Poor Tom, when he falls out of favour with a shifting power structure. When Edgar fears for his life he flees into the countryside, but before he goes he tells the audience about the disguise he will adopt, to avoid detection — and also to help him earn a living.

¹⁴¹ For a demonstration of the way in which mass murder is linked with schizophrenia in sensational magazine articles see, Eugene H. Methvin, 'Bloody murderers', National Review, Vol. 48, No. 10, 3 June 1996, pp. 40-44.

¹⁴² M. S. Humphreys, E. C. Johnstone, J. F. MacMillan, and P. J. Taylor, 'Dangerous Behavior Preceding First Admissions for Schizophrenia', British Journal of Psychiatry, No. 161, 1992, pp. 501-506.

¹⁴³ Anon., 'Families in the Treatment of Schizophrenia', The Harvard Medical School Mental Health Letter, June /July 1989.

¹⁴⁴ Phillip D. Arben, 'Are Mental Illnesses Biological Diseases? Some Public Policy Implications', Health & Social Work, Vol. 21, No. 1, February 1996, pp. 66-70.

My face I'll grime with filth,
Blanket my loins, elf all my hair in knots,
And with the presented nakedness outface
The winds and persecutions of the sky.
The country gives me proof and precedent
Of Bedlam beggars, who with roaring voices,
Strike in their numb'd and mortified bare arms
Pins, wooden pricks, nails, sprigs of rosemary;
And with this horrible object, from low farms,
Poor pelting villages, sheep-cotes, and mills,
Sometime with lunatic bans, sometime with prayers,
Enforce their charity. Poor Turlygood! poor Tom!
That's something yet: Edgar I nothing am.¹⁴⁵

Curiously, DSM-IV now has a diagnostic label for people who fabricate madness in the way that Edgar does. In fact there are two different disorders to choose between. If Edgar were detected in the act of feigning madness by a modern psychiatrist he might be diagnosed with Malingering — but only if the diagnostician thought that ‘enforcement of charity’ was Edgar’s motivation. Malingering is only used when a person is perceived to intentionally produce false or exaggerated psychological or physical symptoms because he or she is apparently “motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.”¹⁴⁶

The alternative diagnosis for feigners of madness is Factitious Disorder — With Predominantly Psychological Signs and Symptoms. This label is used when there is the same intentional feigning “of psychological (often psychotic) symptoms that are suggestive of a mental disorder”¹⁴⁷ and “the motivation for the behaviour is to assume the sick role”.¹⁴⁸ But unlike Malingering, people with Factitious Disorder are not motivated by external incentives like economic gain. Factitious Disorder is also known by the name of Munchausen Syndrome.¹⁴⁹

The existence of these disease categories in DSM-IV points to a somewhat bizarre divergence of opinion between Szasz and mainstream psychiatry. Whereas the existence of Malingering and Factitious Disorder might appear on the one hand to give mainstream confirmation of Szasz’s

¹⁴⁵ William Shakespeare, *King Lear*, Act II, Scene III, in W. J. Craig, ed., *Shakespeare Complete Works*, Oxford University Press, London, 1969, p. 920.

¹⁴⁶ American Psychiatric Association, *op.cit.*, p. 683.

¹⁴⁷ *Ibid.*, p. 472.

¹⁴⁸ *Ibid.*, p. 474.

¹⁴⁹ John B. Murray, ‘Munchausen Syndrome/Munchausen Syndrome by Proxy’, *The Journal of Psychology*, Vol. 131, No. 3, 1997, pp. 343-353.

argument — i.e. that schizophrenia can be simulated — the pathological interpretation of this simulation, by claiming that the production of false symptoms is itself a mental disease, is very different to Szasz's position. What DSM-IV is claiming is that healthy people who pretend to be sick are in fact sick — that the pretence is itself a sickness. Szasz would ridicule this idea.¹⁵⁰

The paradoxical situation that arises from the medicalisation of play-acting is further compounded by the inclusion of a variant of Factitious Disorder, called Factitious Disorder By Proxy (FDBP), in an appendix of DSM-IV.¹⁵¹ FDBP is one of a number of mental disorders that are already recognised by large sections of the psychiatric profession but which have yet to achieve consensual endorsement. In DSM-IV's Appendix B descriptions are given of these disorders and further research into them is recommended.

The essential feature of FDBP:

is the deliberate production of physical or psychological signs or symptoms in another person who is under the individual's care. The motivation for the perpetrator's behaviour is presumed to be a psychological need to assume the sick role by proxy. The perpetrator induces or simulates the illness or disease process in the victim and then presents the victim for medical care while disclaiming any knowledge of the actual etiology of the problem.¹⁵²

If one takes the myth-of-mental-illness model seriously then perhaps FDBP provides the simplest of all explanations for the origins of apparent symptoms of schizophrenia — i.e. they are fabricated by relatives and psychiatrists who are suffering from FDBP and who are adopting the sick role by proxy. But, of course, this point of view presents yet another paradox — if mental illness is indeed a myth, then so is FDBP.

But even if Malingering and the Factitious Disorders present problems of usage within the context of the myth-of-mental-illness model their inclusion in DSM-IV still provides strong confirmation that mainstream psychiatry recognises the possibility that the symptoms of schizophrenia might sometimes only be role-playing. The question to be answered then concerns whether a significant fraction of people diagnosed with schizophrenia are either role-playing themselves, or are the victims of role-playing by relatives and psychiatrists.

Tests have shown fairly conclusively that people without a diagnosis of schizophrenia can fabricate the symptoms on request so well that psychiatrists are willing to diagnose them with schizophrenia.

¹⁵⁰ Szasz, 'Psychiatric Diagnosis, Psychiatric Power and Psychiatric Abuse', *op.cit.*, pp. 135-139.

¹⁵¹ American Psychiatric Association, *op.cit.*, pp. 725-727.

¹⁵² *Ibid.*, p. 725.

The authors of one of these studies using the Rorschach test concluded that all that is required for normal people to successfully simulate schizophrenia is that they have some prior knowledge of the symptoms.¹⁵³ Another survey found that when normal people were coached in the methods of detecting schizophrenic simulation, before undertaking psychometric tests like the Minnesota Multiphasic Personality Inventory, a third of them could feign schizophrenia without detection.¹⁵⁴

However, an accurate knowledge of either the symptoms of schizophrenia, or methods for detecting simulators, might not be necessary for pretenders in real-life situations outside of the laboratory. The much-cited Rosenhan experiment¹⁵⁵ found that a high level of accuracy is not required in the simulation of symptoms, and that practising mental health professionals are unlikely to expose pretenders. Rosenhan enlisted 8 volunteers to act as pseudo-patients. Over a period of time the pseudo-patients presented themselves at 12 psychiatric hospitals and complained of hearing voices saying the words “empty”, “hollow” and “thud”. These words had been chosen because of their existential connotations suggesting the emptiness of life and because they had never appeared in psychiatric literature as being symptoms of mental illness.

No other symptoms were fabricated and on each occasion the pseudo-patients were admitted to the hospitals, and on all but one occasion they were diagnosed as having schizophrenia. After the initial interview the volunteers did not mention the voices again and acted their normal sane selves. The agreement they had made with the co-ordinator of the experiment was that they would each have to gain their own release without any outside assistance. This had to be done by convincing the hospital staff they were sane. The length of hospitalisation ranged from 7 to 52 days with an average of 19 days. All those originally diagnosed as having schizophrenia were released with the diagnosis of “schizophrenia in remission”. One conclusion made by the co-ordinator of the experiment was that, “Psychiatric diagnoses are in the minds of the observers and are not valid summaries of the characteristics displayed by the observed”.¹⁵⁶ Rosenhan’s principal contention was that mental hospitals could not tell the sane from the insane.

Rosenhan was a psychologist and when his study was first published in the journal Science there was widespread protest from members of the psychiatric profession. The next issue of the journal had 15 letters in response, only one of which was favourable.¹⁵⁷ A symposium discussing his experiment was subsequently published in the Journal of Abnormal Psychology. All of the 5

¹⁵³ B. E. Netter and D. J. Viglione Jr, ‘An empirical study of malingering schizophrenia on the Rorschach’, Journal of Personal Assessment, Vol. 62, No. 1, 1994, pp. 45-57.

¹⁵⁴ R. Rogers, R. M. Bagby, D. Chakraborty, ‘Feigning Schizophrenic Disorders on the MMPI-2: Detection of Coached Simulators’, Journal of Personality Assessment, Vol. 60, No. 2, 1993, pp. 215-226.

¹⁵⁵ David L. Rosenhan, ‘On being Sane in Insane Places’, Science, Vol. 179, 19 January 1973, pp. 250-258.

¹⁵⁶ Ibid., p. 251.

¹⁵⁷ Thomas J. Scheff, Being Mentally Ill, Aldine, New York, 1984, p. 190.

psychologists who contributed articles to the symposium were critical of Rosenhan.¹⁵⁸ Most of the criticism was concerned with either the ethics of the experiment or the methodology. The ethical problems mostly focussed on the deliberate intention of deceiving hospital staff which was inherent in the design of the experiment. Only one commentator, Thomas Scheff, writing at a later date, seems to have raised a further ethical question concerning the considerable risks that were taken by the pseudo-patients in subjecting themselves to an average 19 days of incarceration and psychiatric treatments.¹⁵⁹

One of the major criticisms about Rosenhan's methodology was the lack of controls. It was argued by one of the contributors to the symposium that the experiment was of little value because no controls had been used. It was proposed that if there had been a control group which was unaware of the purpose of the experiment then the members of this control group might have tried a lot harder to get out of hospital than did Rosenhan's pseudo-patients.¹⁶⁰

Despite these criticisms Rosenhan's findings still had a considerable impact on the psychiatric profession in the United States by temporarily undermining confidence in the validity of psychiatric diagnoses. Kirk and Kutchins relate how Rosenhan's work particularly affected Robert Spitzer,¹⁶¹ who was one of the principal architects of the DSM revision that became DSM-III: "He obviously took Rosenhan's work very seriously; it constituted a frontal assault on psychiatric diagnosis."¹⁶²

Spitzer challenged Rosenhan in a blustering article entitled "On pseudoscience in science, logic in remission, and psychiatric diagnosis: A critique of Rosenhan's 'On being sane in insane places'".¹⁶³ In this article he offered the simplistic argument that, "A correct interpretation of [Rosenhan's] own data contradicts his own conclusions. In the setting of a psychiatric hospital psychiatrists are remarkably able to distinguish the 'sane' from the 'insane'".¹⁶⁴ Spitzer argued that being released from hospital with "schizophrenia in remission" was tantamount to being found sane.

Although Spitzer claimed a successful refutation, Rosenhan's study is still "often discussed in introductory college courses in psychology and sociology"¹⁶⁵ to illustrate problems with psychiatric

¹⁵⁸ Ibid.

¹⁵⁹ Ibid.

¹⁶⁰ T. Millon, 'Reflections on Rosenhan's On being sane in insane places', Journal of Abnormal Psychology, Vol. 81, 1975, pp. 456-461.

¹⁶¹ Stuart A. Kirk and Herb Kutchins, The Selling of DSM: The Rhetoric of Science in Psychiatry, Aldine De Gruyter, New York, 1992, pp. 90-97.

¹⁶² Ibid., p. 94.

¹⁶³ R. L. Spitzer, 'On pseudoscience in science, logic in remission, and psychiatric diagnosis: A critique of Rosenhan's "On being sane in insane places"', Journal of Abnormal Psychology, Vol. 84, 1975, pp. 442-452.

¹⁶⁴ Ibid.

¹⁶⁵ Kirk and Kutchins, op.cit., p. 93.

diagnosis. It has also recently been recommended in legal literature for use as a courtroom reference to refute the certainty of psychiatric assessments: “Plaintiffs' experts should be asked to admit that psychiatrists can be fooled and that malingering is difficult to detect. In this connection, defence counsel should use the famous Rosenhan study, ...”.¹⁶⁶ Despite the many criticisms Rosenhan’s experiment has survived as a landmark demonstration of how easy it is to simulate symptoms that lead to a diagnosis of schizophrenia.

Another elaborate experiment has demonstrated the converse of Rosenhan’s findings. That is, in order to comply with falsely conceived professional standards, psychiatric and psychological diagnosticians sometimes imagine the symptoms of mental illness in people who are behaving normally. Maurice Temberlin¹⁶⁷ of the University of Oklahoma demonstrated this when he presented a man in perfect mental health for diagnosis by various groups of psychiatrists, psychologists and psychology students. Before these diagnosticians were allowed to observe the man they were supplied with a fabricated suggestion by an expert in the field that the man was mentally disordered.

To set up his experiment Temberlin had a professional actor trained to portray a mentally healthy man using the following criteria:

he was happy and effective in his work; he established a warm, gracious and satisfying relationship with the interviewer; he was self-confident and secure, but without being arrogant, competitive, or grandiose. He was identified with the parent of the same sex, was happily married and in love with his wife, and consistently enjoyed sexual intercourse. He felt that sex was fun, unrelated to anxiety, social-role conflict, or status striving. This was built into his role because mental patients allegedly are sexually anhedonic.¹⁶⁸

The actor’s role also required him to be agnostic and disinterested in extrasensory perception or occult phenomena. This was to avoid the associations with religion and mysticism that are frequently attached to mental patients. He also had a gentle self-mocking sense of humour to combat the normal perception that mental patients are humourless people who have no insight into themselves. The actor’s script required him to deny that he had ever experienced hallucinations, delusions or any other phenomena associated with psychosis.

¹⁶⁶ James T. Brown, ‘Compensation neurosis rides again: a practitioner's guide to defending PTSD claims. (post traumatic stress disorder)’, Defence Counsel Journal, Vol. 63, No. 4, 1996, pp. 467-482.

¹⁶⁷ Maurice K. Temberlin, ‘Suggestion Effects in Psychiatric Diagnosis’, in Scheff, Labelling Madness, op.cit., pp. 46-54.

¹⁶⁸ Ibid., p. 47.

To cap it off a happy childhood was created for him together with mild anxieties about current political affairs, to demonstrate social concern and the absence of self-obsession. His domestic life was happy and only punctuated by occasional disagreements with his wife about church-going, and infrequent musings about whether he was raising his children correctly.

The experiment required a recording to be made of Temerlin interviewing the actor as if he were a prospective patient. In order to account for the clinical setting, so that sickness would not automatically be assumed by the audience, the script described the actor as “a successful and productive physical scientist and mathematician (a profession as far away from psychiatry as possible) who had read a book on psychotherapy and wanted to talk about it”.¹⁶⁹

The actor himself was not told the purpose of the experiment. After the recording was made three clinical psychologists evaluated the interview to ensure that the actor had indeed portrayed a man in perfect mental health. Temerlin then recruited 25 practising psychologists, 25 psychiatrists and 45 graduate students enrolled in doctoral programs in clinical psychology.

The purpose of the experiment was to test whether diagnosticians could be influenced in their clinical judgement by a false statement given by a ‘prestige confederate’. Before the psychologists and psychology students heard the interview they were told by a well-known psychologist who had gained many professional honours that the patient on the taped interview they were about to listen to was “a very interesting man because he looks neurotic, but actually is quite psychotic”.¹⁷⁰ Similarly, the 25 psychiatrists were told that “two board-certified psychiatrists, one also a psychoanalyst, had found the recording interesting because the patient looked neurotic but actually was quite psychotic.”¹⁷¹

Control groups were also tested. One control group was asked to diagnose the actor without any prior prestige suggestion at all. Another group made diagnoses after hearing a prestige suggestion that the actor was mentally healthy. The results were quite extraordinary. As can be seen in the following table the psychiatrists were particularly vulnerable to being misled by the ‘prestige suggestion’.

¹⁶⁹ *Ibid.*, pp. 47-48.

¹⁷⁰ *Ibid.*, p. 48.

¹⁷¹ *Ibid.*

<u>Diagnoses with Suggestion of Psychosis</u>			
	<u>Psychosis</u>	<u>Neurosis</u>	<u>Mental Health</u>
Psychiatrists (25)	15	10	0
Clinical Psychologists (25)	7	15	3
Psychology Students (45)	5	35	5
<u>Control Groups</u>			
	<u>Psychosis</u>	<u>Neurosis</u>	<u>Mental Health</u>
No prestige suggestion (21)	0	9	12
Suggestion of mental health (20)	0	0	20

Adapted from: Maurice K. Temerlin, 'Suggestion Effects in Psychiatric Diagnosis', in Thomas J. Scheff, Labelling Madness, Prentice-Hall, Englewood Cliffs N.J., 1975, p. 50.

Schizophrenia was the most common form of psychosis diagnosed and the results in many ways speak for themselves. Unfortunately Temerlin did not break down the control group results into psychiatrists, psychologists, and students. However he did indicate that the second control group was comprised of all three types: "when the prestige confederate of control group 2 said, 'You know, I think this is a very rare person, a perfectly healthy man', psychologists, psychiatrists, and graduate students agreed unanimously".¹⁷²

After analysing the data Temerlin concluded that professional identity was the relevant variable and that there was no relationship in diagnostic outcomes with either length of training or experience. What is apparent is that the psychiatrists in particular were inclined to adopt a professional role-play after the appropriate script was supplied to them by a prestige confederate, whose opinion could be assumed to represent professional standards.

In attempting to explain why the psychiatrists were more easily led into diagnosing a healthy person as psychotic Temerlin observed that: "Psychiatrists are, first and foremost, physicians. It is characteristic of physicians in diagnostically uncertain situations to follow the implicit rule 'when in doubt, diagnose illness', because it is a less dangerous error than diagnosing health when illness is in fact present."¹⁷³ This point was punctuated by a statement from one psychiatrist who, after learning about his error, defended a diagnosis of psychosis by arguing: "Of course he looked

¹⁷² Ibid., p. 51.

¹⁷³ Ibid., p. 52.

healthy, but hell, most people are a little neurotic, and who can accept appearance at face value anyway?"¹⁷⁴

One is tempted to speculate about the role of patient fees in this apparent willingness to diagnose mental illness in healthy people. DSM-IV identifies Malingering as a diagnosis for use when patients fabricate symptoms for personal gain. But, unlike Factitious Disorder, the manual does not supply a proxy complement of Malingering which could be used when mental health professionals fabricate symptoms for their personal gain. It is not surprising that Malingering By Proxy fails to even make it into Appendix B, as an area recommended for further research. But this omission leaves the way open for cynics to argue that the compilers of DSM-IV might have insufficient insight into the real cause of at least some supposed mental illness.

Conclusion

The medical and mystical models both accept the defining characteristic of schizophrenia as self-evidently being concerned with abnormal psychological experience. On this point the myth-of-mental-illness (M-M-I) model deviates from both of them and instead argues that there is no significant psychological abnormality involved and that the abnormality that distinguishes schizophrenics from normal people actually concerns their social relationships, not their minds. When abnormal mental experiences are claimed by schizophrenics, the M-M-I model explains them as being fabrications.

In order to analyse these premises this chapter divided the M-M-I model into three sub-types. Each of these sub-types was found to have plausible arguments and supporting evidence. But this division into three sub-types was only devised as a convenient tool of analysis and it is unlikely that any single one of these sub-types, by itself, could stand up against the medical model. However, when they are combined the M-M-I model provides a powerful alternative explanation.

The wide range of symptoms for schizophrenia, without any certain common denominator, combined with the subjective diagnostic methods, that have no laboratory support, ensure that some cases of schizophrenia will always be best explained by one or another of the M-M-I sub-types. However, there are other cases, particularly those where an unusual inner experience is convincingly described personally by the schizophrenic, for which the M-M-I explanations seem thoroughly inadequate.

All this points to a plurality of types of people who receive diagnoses of schizophrenia. Practitioners of the medical model themselves frequently refer to schizophrenia in the plural when they are prepared to acknowledge the 'grab-bag' nature of their diagnostic criteria:

¹⁷⁴ Ibid.

The ‘group of schizophrenias,’ normally referred to with a single nominative, is phenomenologically heterogeneous. Its symptoms represent multiple psychological domains, including perception, inferential thinking, language, attention, social interaction, emotion expression, and volition.¹⁷⁵

There is current movement within the psychiatric profession to further widen the diagnostic criteria for schizophrenia to include prodromal symptoms.¹⁷⁶ These are the supposed early, pre-psychotic signs and people who are identified as having them are said to have early psychosis.¹⁷⁷ If the M-M-I model is a useful tool for explaining many supposed cases of full-blown schizophrenia it is likely to be even more valuable for explaining this growth area of schizophrenia. It is proposed to test each of the three models — the medical, mystical and M-M-I models — for applicability to early psychosis in Chapter 10.

¹⁷⁵ N. C. Andreasen, S. Arndt, R. Alliger, D. Miller and M. Flaum, ‘Symptoms of schizophrenia: methods, meanings, and mechanisms’, Archives of General Psychiatry, Vol. 52, No. 5, May, 1995, pp. 341-351.

¹⁷⁶ A. K. Malla, and R. M. Norman, ‘Prodromal Symptoms in Schizophrenia’, British Journal of Psychiatry, Vol. 164, No. 4, 1994, pp. 487-493.

¹⁷⁷ Thomas H. McGlashan, ‘Early Detection in Schizophrenia: Editor’s Introduction’, Schizophrenia Bulletin, Vol. 22, No. 2. 1996, pp. 197-199.