

De-Medicalizing Misery

Psychiatry, Psychology and the Human Condition

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Contents

<i>Preface: Rudi Dallos</i>	vii
<i>Acknowledgements</i>	ix
<i>Notes on Contributors</i>	xi
1 Carving Nature at its Joints? DSM and the Medicalization of Everyday Life <i>Mark Rapley, Joanna Moncrieff and Jacqui Dillon</i>	1
2 Dualisms and the Myth of Mental Illness <i>Philip Thomas and Patrick Bracken</i>	10
3 Making the World Go Away, and How Psychology and Psychiatry Benefit <i>Mary Boyle</i>	27
4 Cultural Diversity and Racism: An Historical Perspective <i>Suman Fernando</i>	44
5 The Social Context of Paranoia <i>David J. Harper</i>	53
6 From Bad Character to BPD: The Medicalization of 'Personality Disorder' <i>James Bourne</i>	66
7 Medicalizing Masculinity <i>Sami Timimi</i>	86
8 Can Traumatic Events Traumatize People? Trauma, Madness and 'Psychosis' <i>Lucy Johnstone</i>	99
9 Children Who Witness Violence at Home <i>Arlene Vetere</i>	110
10 Discourses of Acceptance and Resistance: Speaking Out about Psychiatry <i>Ewen Speed</i>	123
11 The Personal is The Political <i>Jacqui Dillon</i>	141

12	'I'm Just, You Know, Joe Bloggs': The Management of Parental Responsibility for First-episode Psychosis <i>Carlton Coulter and Mark Rapley</i>	158
13	The Myth of the Antidepressant: An Historical Analysis <i>Joanna Moncrieff</i>	174
14	Antidepressants and the Placebo Response <i>Irving Kirsch</i>	189
15	Why Were Doctors So Slow to Recognize Antidepressant Discontinuation Problems? <i>Duncan Double</i>	197
16	Toxic Psychology <i>Craig Newnes</i>	211
17	Psychotherapy: Illusion with No Future? <i>David Smail</i>	226
18	The Psychologization of Torture <i>Nimisha Patel</i>	239
19	What Is to Be Done? <i>Joanna Moncrieff, Jacqui Dillon and Mark Rapley</i>	256
	<i>Notes</i>	259
	<i>Bibliography</i>	264
	<i>Index</i>	295

1

Carving Nature at its Joints? DSM and the Medicalization of Everyday Life

Mark Rapley, Joanna Moncrieff and Jacqui Dillon

There's a place in Freud where he says, 'with regard to matters of chemistry or physics or things like that, laymen would not venture an opinion. With regard to psychology it's quite different; anybody feels free to make psychological remarks'. And part of the business he thought he was engaged in was changing that around; that is, cojointly to develop psychology and educate laymen, so that laymen would know that they don't know anything about it and that there are people who do, so that they would eventually stop making psychological remarks.

(Sacks, 1992: 217)

It is surely now apparent that after nearly 130 years of recognizably modern psychiatry and psychology (the 'disease' *Dementia Praecox* first appeared as a recognizable diagnosis in the fourth German edition of Emil Kraepelin's *Lehrbuch der Psychiatrie* in 1893 and William James published his *Principles of Psychology* in 1890), the enterprise is, to put it mildly, problematic. The architects of modern biological psychiatry have constructed a system that does little justice to the myriad problems it claims to address, while creating multiple iatrogenic problems for those to whom it is applied. Mainstream psychology likewise, while sometimes appearing to offer alternative approaches, essentially supports the positivist psychiatric project of codifying human suffering into disease-like categories. Yet, it would seem, more than a century of intensive psychiatric research has yet to find *any* form of organic grounding for the overwhelming majority of the 'mental disorders' listed in the DSM and psychology likewise has failed to provide any coherent alternative

justification for this attempt to catalogue the 'problems of living' (Szasz, 1960: 115). As such we – along with many others, including parts of the popular media (Carey, 2010; Laurance, 2010) – are compelled to conclude that the effort to codify various forms of misery and disturbing conduct *as if* they were physical diseases, far from being another triumph of modern science – carving nature at its joints *a la* Linnæus or the periodic table (Mendeleev, 1901) – is, rather, best regarded as fiction or, more kindly, in Barthes' sense, as mythology.

But that mythology defines our present. It would seem that Sigmund's project (ably assisted by the pharmaceutical industry and the professions of psychiatry, clinical psychology and their associated partners in the psy-complex (Rose, 1996)) has been a spectacular success. Not in the way that he imagined, for sure, but resoundingly to the benefit of his professional heirs and successors: that is to say we inhabit a culture positively drowning in a cacophony of American Psychiatric Association-authorized 'psychological remarks' (Hansen, McHoul & Rapley, 2003).

In this book we draw together a range of contributors who, like us, take the view that the human costs of the medicalization of misery and madness outweigh any benefit that the metaphoric transformation of suffering into 'disease' may once have offered. With the impending arrival of DSM 5 (the future reach of which may be presaged by a presence on Twitter and Facebook – with 10,227 Facebook 'fans' as of 17 February 2011!) it is timely to ask whether there may be better ways to make sense of the range of human experiences we have come to know as 'mental disorders'.¹ The timeliness of this questioning is only enhanced by the ever-widening net of 'mental disorder' that the DSM seeks to cast over unhappiness, personal misfortune and troubling conduct. For example, the devoted website DSM5.org alerts us to the fact that the appropriate expert committee has now set out revised criteria for 'Reactive Attachment Disorder of Infancy and Early Childhood' (see Box 1.1).

As the criteria illustrate, the APA (advised by 'more than 600 global experts in the field of mental health' and 'representing 38,000 physician leaders in mental health', DSM5.org, 2010) seriously suggests that children being miserable (having 'limited positive affect') and distressed (showing 'irritability, sadness, or fearfulness') – is best described as the child having a 'mental disorder' afflicting *them*. That this is not an inexplicable or 'inappropriate' 'condition', but the well-documented, entirely understandable and absolutely sensible consequence of long-standing child abuse is, actually, apparent from

Box 1.1 Proposed DSM-V Criteria for Reactive Attachment Disorder of Infancy or Early Childhood

A A pattern of markedly disturbed and developmentally inappropriate attachment behaviors, evident before 5 years of age, in which the child rarely or minimally turns preferentially to a discriminated attachment figure for comfort, support, protection and nurturance. The *disorder* appears as a consistent pattern of inhibited, emotionally withdrawn behavior in which the child rarely or minimally directs attachment behaviors towards any adult caregivers, as manifest by both of the following:

- (1) Rarely or minimally seeks comfort when distressed.
- (2) Rarely or minimally responds to comfort offered when distressed.

B A persistent *social and emotional disturbance* characterized by at least 2 of the following:

- (1) Relative lack of social and emotional responsiveness to others.
- (2) Limited positive affect.
- (3) Episodes of *unexplained* irritability, sadness, or fearfulness which are evident during nonthreatening interactions with adult caregivers.

C Does not meet the criteria for Autistic Spectrum Disorder.

D *Pathogenic care* as evidenced by at least one of the following:

- (1) *Persistent disregard of the child's basic emotional needs* for comfort, stimulation, and affection (i.e., neglect).
- (2) *Persistent disregard of the child's basic physical needs*.
- (3) *Repeated changes of primary caregiver* that prevent formation of stable attachments (e.g., frequent changes in foster care).
- (4) *Rearing in unusual settings* such as institutions with high child/caregiver ratios that limit opportunities to form selective attachments.

E There is a presumption that the care in Criterion D is responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion D).

F The child has a developmental age of at least 9 months. (DSM5.org, 2010, our emphases).

the criteria. However, instead of stating the obvious fact that abusive childrearing practices produce distressed children who have learnt to be fearful of adults, highly convoluted language is used to concede, in Criterion E, that children's conduct which has *already been claimed* as a 'mental disorder' is 'presumed' to be the outcome of 'pathogenic care'.²

As others have pointed out, to describe what are actually, and essentially, morally troubling issues – in this case children behaving in ways which make manifest their adult-created misery – (misery consequent upon 'persistent disregard of ... basic emotional needs (i.e., neglect) ... persistent disregard of ... basic physical needs') or straightforwardly matters of material circumstance (being brought up in 'unusual settings such as institutions with high child/caregiver ratios' or being subject to 'pathogenic care') as *medical conditions* is to make a moral – not a 'scientific' – choice in and of itself (cf. Bentall, 1992), and moreover, strains the medical metaphor past breaking.

Although Reactive Adjustment Disorder may seem an extreme example, the more familiar 'mental disorders' share the same dynamics, with more or less understandable reactions to life's challenges de-contextualized and transformed into internal individual pathology – whether labelled as depression, psychosis or some other diagnosis. In other words, the relentless widening of the mythical net of 'mental disorder' is seriously corrosive of the sense that we can have, and make, of our selves and our circumstances.

Quite aside from serving the sorts of professional and commercial interests documented by Irving Kirsch, Sami Timimi, David Smail, Duncan Double, Joanna Moncrieff and Craig Newnes among others in this volume, this corrosion of the dignity of 'lay' human selfhood perpetuated by the medicalization of suffering and difference thrives because it sanitizes and simplifies. The moral complexity and ambiguity that is inherent in the enterprise of policing human conduct is neatly reduced to the morally neutral and more predictable activity of managing a bodily disease. In Szasz's words, the myth that is 'mental illness' functions to 'render more palatable the bitter pill of moral conflict in human relations' (Szasz, 1960). Medicalization enables those who work in the mental health professions to manage the human suffering that they are daily confronted with, and also the nagging concern that there is little that they can do to help. In the process, as Mary Boyle and David Smail point out in their contributions, the people behind the 'disorders' may be overlooked, and the social

circumstances that cause or contribute to their suffering often go unexamined and unchallenged.

Much of this volume is dedicated to exposing the linguistic contortions by which the transposition of social, moral and political issues into disease is achieved. In keeping with our position, and following Schütz (1962), here then we deliberately employ the vernacular. That is to say, we *can* (and here *do*) talk, sensibly, in everyday terms, about madness, grief, misery, distress, confusion, hopelessness, craziness, despair and so on through the rich and perfectly well-fitted lexicon of human suffering that the English language provides. In doing so we hope to foreground a contrast to Freud, Kraepelin, the APA et al. and the other weavers of the mythic language by which contemporary psy has rendered laymen unable to make 'psychological remarks' uninflected by its nostrums. That is we do not take the view that 'psychological remarks' should be the exclusive preserve of the professions: rather we take the view that ordinary people, using ordinary language, 'have perfectly good and sufficient descriptions of themselves' (McHoul, 2008: 4).

Taking seriously Wittgenstein's remark that 'our talk gets its meaning from the rest of our proceedings' (1975: 229), what we seek to do in this collection is, then, to return the capacity to make meaningful psychological remarks to its proper place in 'our proceedings', to restore to quotidian discourse a way of 'inventing ourselves' (*pace* Rose, 1996) that, unlike contemporary psy, recognizes and respects the essential *humanness* of the human condition.

De-Medicalizing Misery is, simply, a shorthand term for this project. Resisting the psychiatrization and psychologization of almost every aspect of human experience, and finding a way to place what are, frequently, essentially *moral and political* – not *medical* – matters back at the centre of our understanding of human suffering is a massive and multifaceted task. In consequence our contributors address a range of aspects of this project.

At this point we feel it important to gratefully acknowledge the observation of an anonymous reviewer that our contributors take various different approaches. Whereas some of the contributions are recognizably standard academic pieces, others are personal viewpoints and hence – while perhaps not best judged according to conventional academic standards – offer a complementarity to 'academic' material. Equally, the volume is not intended as a comprehensive critique of psychiatry and psychology: we acknowledge that many other writers,

from diverse disciplinary fields, have made cogent and powerful critiques of this area. In particular we are conscious that much of the debate in sociology is perhaps under-represented. Of course, since Goffman's (1961) *Asylums* and Garfinkel's earlier observations on degradation ceremonies (1956a, b) sociologists have elaborated on these foundations and made penetrating critiques of the psy professions, and a debt to their work is owed not only by us as editors but also by many of our contributors. More recently, the sociological work of academics such as Pilgrim and Rogers (2003; 2005; 2010) and McCabe and colleagues (2002; 2004), while clearly congruent with our project, makes an important and distinctive contribution. This perspective is not omitted by design, but rather the selection of contributors to this volume reflects many factors, including prosaic practical considerations as well as issues of topicality at the time of writing. We hope, however, that this does not unduly detract from the relevance of the collection presented here.

In opening, Phil Thomas and Pat Bracken straightforwardly ask 'what does it mean to "demedicalize misery"?' and examine how the persistence of dualist thought in Western philosophy and culture helps in sustaining the idea of 'mental' illness as the ghostly partner in crime of 'physical' illness. Maintaining the focus on the 'macro' – the epistemological, the political and the discursive – Mary Boyle examines the strategies that psychology and psychiatry deploy in their relentless efforts to 'make the world go away', and how they benefit from these endeavours, at whatever cost to theoretical coherence and practical utility. Some of the upshots of this Cartesian legacy, and professional efforts to discount the materiality of the world in the production of distress, are examined by Suman Fernando. He notes that the disciplines that inform mental health services (mainly psychiatry and Western psychology) have grown out of a particular culturally determined understanding of the human condition, ideologies about life and so on, generally termed 'Western culture', and are at variance with – sometimes in conflict with – understandings and ideologies in 'other' cultures: such a reality disjuncture, he suggests, plays a crucial role in the disproportionate pathologization of non-white citizens in the UK.

Developing the concentration on the incoherence of medicalized understandings of forms of conduct, Dave Harper critically interrogates the notion that being wary, mistrustful and suspicious of others is best understood as a specific form of psychiatric disturbance, a 'symptom' of 'mental disorder' known as 'paranoia'. In passing, paranoia is a particularly interesting inversion of what is now commonplace

psychiatric practice in that – etymologically at least – it appears since the early 1800s to have suffered relegation from being a generalized descriptor of insanity *tout court* to being merely a ‘symptom’ of other forms of madness (from Gk. *paranoia* ‘mental derangement, madness’, from *paranoos* ‘mentally ill, insane’ from *para* – ‘beside, beyond’ + *noos* ‘mind’: Online Etymology Dictionary, 2010). In an examination of the more ‘traditional’ trajectory of psychiatric disease creation, James Bourne examines how everyday, but socially problematic, ways of being-in-the-world which may once have been described as resulting from a ‘flawed character’ or a ‘lack of breeding’ mutated into the psychiatric ‘condition’ called ‘Borderline Personality Disorder’.

Our focus on the use of language to cast the mythical net of ‘mental disorder’ continues in chapters by Arlene Vetere, Lucy Johnston and Sami Timimi. Here – picking up on some of Mary Boyle’s arguments about the essentially *social* nature of distress – the focus is on the way in which psy actively seeks to divorce persons from their social worlds in making sense of madness and misery, and to delete from our thinking of ourselves notions such as Sartre’s (1944/1989) insight that ‘*l’enfer: c’est les autres*’. Sami Timimi explores how psychiatric discourse about children’s emotions and behaviour, centred as they are around the notion that inconvenient behaviour can be helpfully curbed by the use of drugs, have contributed to a dramatic change in our views about, and practices towards, childhood and child-rearing. Both Arlene Vetere and Lucy Johnstone examine the relationship between terrifying childhood experiences (‘trauma’) and later difficulties in living, sometimes described as ‘psychosis’.

Contra DSM5.org, Vetere makes it abundantly clear that children who grow up exposed to chronic fear, sadness, shame, worry, the threat of – and actual – violence in their lives are – unsurprisingly – often likely to learn to find the world frightening, and people in it a doubtful source of kindness and love. That some of the ways that the grown-ups these children become deal with the lasting lessons of their childhood are described as ‘symptomatic’ of ‘mental disorder’ obliterates their suffering and invalidates their experience and sense of self; one of the ways such children may come to be described is as ‘having’ a ‘psychosis’.

The term ‘psychosis’, Johnstone argues, is presented as more user-friendly and less stigmatizing than a diagnosis of ‘schizophrenia’. However, she shows clearly that it is equally, if not more, problematic in terms of reliability, validity and so on, while its woolliness serves to disguise and defuse fundamental critiques about the nature, purpose

and consequences of psychiatric diagnosis. While Vetere's and Johnstone's chapters are based on a review of academic literature and empirical social research, Jacqui Dillon describes, from first-hand experience, exactly what this life course means.

The wider social consequences of the psychiatric endeavour are outlined in chapters by Ewen Speed, Jacqui Dillon and Carlton Coulter and Mark Rapley. We have noted that one of the effects of the widespread acceptance of the medicalized mythology of the present is that it obliterates suffering and invalidates experience. Countering this silencing, and providing a platform for voices of the mad and their families, is an essential part of our project. As such, Ewen's chapter discusses the politics of self-identification among recipients of mental health services. Picking up from Sami Timimi's chapter on the medicalization of childhood, Carlton Coulter and Mark Rapley examine the anguish and uncertainty expressed by the parents of children diagnosed as 'psychotic' occasioned by the conflicting stories that psychiatry tells about parental responsibility, 'mental-illness-as-biological-derangement' and 'mental health literacy' in trying to make sense of their moral accountability for their child's distress.³

Quite aside from the adverse effects on persons and families of their acceptance – in good faith – of the contemporary mythology of interiorized, individualized mental pathology, psychiatry's claims about its scientificity demand further scrutiny. In chapters by Joanna Moncrieff, Irving Kirsch and Duncan Double the idea, the evidence and the means by which we have come to be persuaded of the contemporary cultural commonsense that 'depression' is a 'chemical imbalance in the brain' are explored. Joanna Moncrieff lays bare how the very idea that there could be such a thing as an 'antidepressant' was constructed to present psychiatry as a modern medical enterprise with proper medical treatments and not, as we are so often assured, a consequence of sophisticated research on brain biochemistry. Irving Kirsch subsequently – and comprehensively – debunks the hypothesis that the *soi-disant* 'antidepressants' have a specific biochemical effect on a 'mental disorder' called 'depression'. The ill effects of such cultural commonsense are explored by Duncan Double, who asks why doctors were so slow to recognize antidepressant-discontinuation problems. While Moncrieff and Kirsch demonstrate that the scientific status of what WHO claims is the world's leading cause of disability is lacking, Duncan Double shows very clearly what is at stake, and how this stake is managed.

If Moncrieff, Double and Kirsch are sceptical about the efficacy of the pharmacological 'magic bullet', Nimisha Patel, David Smail and

Craig Newnes are similarly sceptical about the much vaunted efficacy of psychological – as opposed to medical – understandings of misery and the much vaunted solution to it, the ‘talking cure’ – psychotherapy. The workings of the world, of material reality, are central to Craig Newnes’ analysis of the harms done as part of the political game clinical psychology has played to ensure the profession’s survival. Smail continues this line of analysis and suggests that therapeutic psychology, ‘the great red herring of the twentieth century’, is not – as proponents of NICE guidelines would have it – the pinnacle of ‘evidence-based practice’, but rather an ideological masterstroke which obscures the significance for emotional suffering of the social structure of material reality. Nimisha Patel takes the issue of torture as a worked example of the pitfalls of neglecting to acknowledge and to theorize the socio-political context in making sense of distress.

To return to where we started, it would seem that a rethink of the ways we currently comprehend – and respond to – madness and misery is long overdue. However much psy might wish it, the world will not ‘go away’. It is time to call time on Sigmund’s project. We close this collection, then, with some very brief concluding remarks by Jacqui Dillon, Joanna Moncrieff and Mark Rapley offering some observations on what such a reconfigured understanding may look like, and some – tentative – pointers towards that goal.

2

Dualisms and the Myth of Mental Illness

Philip Thomas and Patrick Bracken

What does it mean to 'de-medicalize misery'? Does it mean that we should no longer think of states of despair, sadness and madness in medical terms? Does it mean that there is no proper role for doctors in trying to work with and help those so afflicted? And if that is so, then what is to be done about the systems that Western societies have set up to help, such as mental health and primary care services, all of which are predicated on the assumption that misery and madness are, among other things, medical conditions? Are all these to be dismantled? If so, what should take their place? These are not rhetorical questions; they serve the point of drawing attention to the fact that words have important consequence, if we mean what we say.

The idea that we should de-medicalize misery has a mixed pedigree. The arguments that have made it possible for us to say such a thing originate in vastly different ideologies and forms of knowledge. Sociology, history, philosophy, Marxism, right-wing libertarianism, and more recently some survivors and service users, as well as academics in anthropology, feminism, post-colonial and cultural studies have all made contributions of one sort or another to the argument that the profession of medicine has no legitimate role to play in misery and madness. They have all, to varying degrees, raised serious questions about the role of medical knowledge and doctors in this field.

One of the most pungent and enduring critics of the role of medicine in misery is the American psychiatrist and academic, Thomas Szasz. It is exactly 50 years since the publication of his paper *the Myth of Mental Illness* (Szasz, 1960), in which he argued that hysteria is better understood as a problem of personal behaviour aimed at seeking help. A year later in the book of the same name, he extended his argument to the full range of psychiatric conditions, including schizophrenia. His ideas have been enormously influential, paradoxically nowhere more so than

in the profession of psychiatry itself. Wilson (1993) has described how the onslaught of Szasz and other anti psychiatrists¹ led to a hardening of the profession's positivistic tendencies, and the emergence of DSM 3 and neo-Kraepelinism.

In this chapter we extend our analysis of Szasz's ideas that we started elsewhere (Bracken & Thomas, 2010). Here we focus on some aspects of the philosophical assumptions that underpin Szasz's arguments, specifically in so far as these are relevant to the idea that we should, or could, de-medicalize misery and madness. We begin with a detailed examination of Part One of the *Myth of Mental Illness*, drawing attention to the philosophical ideas about the nature of subjectivity that lie at the heart of his arguments – Cartesian dualism. Although Cartesianism has been immensely influential in Western philosophy over the last 350 years, key strands of thought in Continental philosophy in the twentieth century have exposed the failure of Cartesianism to provide anything like a realistic account of human subjectivity. For this reason we turn to the philosophy of Maurice Merleau-Ponty, particularly his view that we are embodied beings, to examine the implications of Szasz's ideas for our understandings of ourselves. We also draw on recent work in anthropology that reveals the complex relationship between neurological disease, psychosis and culture. We conclude that, rather than de-medicalizing misery, we really require a completely different form of medicine, one that unlike Szasz, avoids the pitfalls of dualisms.

Our distaste for dualistic approaches to human reality stems ultimately, not from philosophy, but from our experiences as doctors, and in particular, from our work with individuals and families from non-Western communities. Through this work we have become sensitized to the different ways in which human beings experience their bodies in relation to disease, distress and states of madness. While Szasz might be right that certain pathological processes can be identified in human bodies cross-culturally, the reality is that the human experience of disease varies greatly and cannot be disentangled from the cultural context in which the individual exists. Likewise, all forms of medical understanding and practice are laden with cultural assumptions, values and operate according to different priorities. Szasz rightly sees psychiatry in this light but fails to see that psychiatry is not alone in this.

Body or mind in the *Myth of Mental Illness*

In the introduction to the *Myth of Mental Illness*, Szasz declares that the methods and subject matter of psychiatry have more in common

with studies in linguistics and philosophy. Despite this, psychiatry's contemporary conceptual framework remains firmly within the tradition of medicine, and is thus rooted in the natural sciences. He sees this as an anomaly, and he highlights the confusion that exists in psychiatry over the relationship between the physical and mental worlds, through a logical analysis of language use influenced by the ideas of the Vienna Circle.² Later Szasz turns to American pragmatism, particularly the ideas of George Herbert Mead, to develop a model of the doctor-patient relationship based in game playing. He also draws on Popper's critique of historicism,³ arguing that the key principles of natural science, causality and determinism cannot be carried over into the human sciences. This is because he is concerned about the negative implications such a move would have for the possibility of free will. Here, however, we are primarily concerned with Szasz's views about the relationships between the physical and mental worlds, and his reliance on the philosophy of the Vienna Circle.

His analysis begins with an examination of the philosophical assumptions that are to be found in the work of the founders of psychoanalysis, focussing particularly on Charcot and Freud's writing on hysteria and conversion syndromes. Szasz points out that hysteria developed in the reverse order from that which usually characterizes the way in which medicine identifies new diseases. Charcot effectively created a new criterion for what constitutes a disease: 'paresis was proved to be a disease; hysteria was declared to be one' (Szasz, 1974: 12). He points out that Charcot was in a position to make such a declaration,⁴ but beneath this he identifies a deep-seated confusion about the body-mind relationship. This persists in contemporary psychiatry. Szasz may have a point here, but we will argue that his position is dualistic. He denies that those conditions identified as psychiatric disorders have any bodily basis, and, furthermore, that they are all to be accounted for in moral terms, or in terms of problem behaviours:

This dichotomy is reflected in the two basic contemporary psychiatric methods, namely the physicochemical and the psychosocial. In the days of Charcot and Freud, however, only the former was recognized as belonging to science and medicine. Interest in the latter was synonymous with charlatany and quackery.⁵

(Szasz, 1974: 27–8)

Szasz insists that there are clear limits to what we can legitimately describe as illness. Disturbances in bodily functions are correctly to

be understood in terms of pathology, but difficulties in our beliefs, emotions, relationships and behaviour are primarily moral problems, and it is not appropriate to talk of these in terms of illness. This view has been a firm and consistent feature of Szasz's writings throughout his illustrious career extending over 50 years. In a recent work he writes as follows: 'I maintain that mental illness is a metaphorical disease: that bodily illness stands in the same relation to mental illness as a defective television set stands to a bad program' (Szasz, 2007: 6).

He proposes that we require two distinct discourses, one to describe the functioning of the television set, another to describe the quality of the programme. By extension, we cannot 'cure' psychological problems by interfering with the body of the person who experiences these problems, just as tinkering around with the internal components of a television set will not provide a better programme. We should not use the language and logic of pathology to frame psychological problems.

This confusion between mental worlds and physical worlds lies at the heart of the problem of psychiatry, as Szasz sees it. It is a stumbling block (to use his expression) that underpins the differential diagnosis between hysteria and neurological disorders. It also stands in the way of a 'systematic theory of personal conduct free of brain-mythological components' (Szasz, 1974: 28). This is important in understanding Szasz's position. One of his objectives in disposing of a neurobiological account of human action is to clear the way for a moral basis for personal conduct in the second part of his book. But in trying to dispose of what might be seen as psychiatry's confused monism he substitutes instead body-mind dualism.

This emerges most clearly in his account of Freud and Breuer's early description of hysteria in Chapters 4 and 5. Szasz argues that Freud's theory of conversion helped to deal with the dualistic question of how an emotional problem can present as a physical symptom. He acknowledges that such a question presupposes Cartesian dualism (although he does not specify what sort of dualism arising from Descartes' philosophy he is referring to), and then argues that the concept of conversion is misleading because, as we have seen, it involves confusion between two different languages or modes of representation, the psychological and physical. However, Szasz's solution to the problem of the body-mind relationship as far as psychiatry and medicine are concerned is to abandon one wing of it altogether:

The only viable alternative to this familiar but false perspective is to abandon the entire medical approach to mental illness and to

substitute new approaches for it appropriate to the ethical, political, psychological and social problems from which psychiatric patients suffer and which psychiatrists ostensibly seek to remedy.

(Szasz, 1974: 79)

Szasz insists that we see everything in black or white. It makes no sense, he argues, to use the language of pathology to talk about distress or madness, because these are fundamentally moral problems of one sort or another. The language of pathology is only relevant to physical diseases affecting the body. In terms of how we think and act as doctors, the two worlds, mental and physical, must be kept apart.

It is his argument about the confusion in psychiatry when dealing with the mental and physical worlds that reveals most clearly the influence of the philosophy of the Vienna Circle. He draws on the work of Moritz Schlick (one of the founder members of the Circle), citing his warning against the confused use of words from 'different languages'. He points out that this is precisely what happens when we talk about 'psychosomatic' medicine, and he goes on to attack psychiatry's use of words such as 'organic', 'psychogenic', and 'mental illness' as further instances of 'linguistic misuse'. He is particularly critical of the work of Franz Alexander who, in the emerging field of psychosomatic medicine, made the distinction between conversion hysteria and organ neurosis. Alexander saw no distinction between mental and physical worlds as far as illness was concerned. Szasz accuses him of

ignor[ing] the linguistic and legal, epistemological and social, and all the other distinctions between psychological and physiological events and pursuits, and simply assert[ing] that 'psychic and somatic phenomena take place in the same biological system and are probably two aspects of the same process'.

(Szasz, 1974: 87)

Szasz argues that if we make no distinction between medicine and psychology, then why should we bother to distinguish between medicine and religion, or medicine and the law, or medicine and politics. By implication this is an absurd position. At the same time he asserts his own opposition to any form of holism (as opposed to dualism):

In any case, we cannot have it both ways: we must choose between the psychophysical symmetry of modern psychosomatic medicine, fashionable in medicine and psychiatry today, and the psychophysical

hierarchy of modern philosophy, opposing contemporary efforts to medicalize moral problems.

(Szasz, 1974:87)⁶

We broadly agree with Szasz's analysis of the problem of the body in relation to psychiatry, at least as far as there is no clear evidence that the different categories of 'mental illnesses' as currently defined have readily identifiable pathological causes. Elsewhere we have written about the limitations and failings of the biomedical model in psychiatry (Bracken & Thomas, 2005; see Chapter 6). However, we part company with him when he starts to prescribe what sort of suffering is legitimate from a medical point of view. We believe that his imposition of a strictly dualistic solution to the mind-body relationship in medicine and psychiatry is seriously misguided. His insistence that bodily and mental worlds are distinct domains to be spoken about only in their own terms overlooks the symbolic meaning of the body and biology in our lives. Although he correctly, in our view, points out that the concept of mental illness is a metaphor, he fails to acknowledge that diseases, physical illnesses and the body all possess metaphorical significance and meaning in our lives.⁷

Elsewhere, we have contrasted Szasz's analysis of the problems of psychiatry with the work of Michel Foucault. Szasz's approach is predicated on a number of simple binary distinctions (Bracken & Thomas, 2010). In this chapter we are focussing in detail on one aspect of this, his understanding of the body-mind relationship and the role it plays in relation to physical illness, distress and madness. An important consequence of this is his claim in Chapter 3 of the *Myth of Mental Illness*, that in physical medicine culture has no role to play. He asserts that the manifestations of physical diseases are largely independent of culture or socio-political conditions in general: '[A] diphtheritic membrane was the same and looked the same whether it occurred in a patient in Czarist Russia or Victorian England' (Szasz, 1974: 48). He maximizes the polarization between mental and physical illness by asserting that although the 'phenomenology' (his word) of bodily illness such as tuberculosis is not influenced by socio-cultural factors, this is most certainly the case as far as mental illness is concerned:

[t]he phenomenology of so-called mental illness ... depend[s] upon and var[ies] with the educational, economic, religious, social and political character of the individual and the society in which it occurs.

(Szasz, 1974: 48–9)⁸

It may be the case that when people from different cultural or religious backgrounds become ill, their bodies display the same physical derangements. But the danger here is that we overlook the relationship between culture and the personal meaning and significance of bodily disease. Szasz engineers a radical disconnection between the world of culture and medicine, which in his analysis can only be spoken about in terms given to us by natural science. At a stroke he dismisses the work of medical anthropologists and writers in the field of medical humanities, who have shown that diseases have meanings for us, and that the interaction between meaning and pathology is a complex and vital factor in understanding the outcome of disease and treatment.

Before we move on to a philosophical critique of dualisms in the *Myth of Mental Illness* we will briefly summarize what we have gleaned so far.

Szasz sets out three main propositions. First is the idea that mental diseases are metaphorical, and thus not real; second is the idea that physical diseases are 'real' in the literal sense; third, that the 'phenomenology' of physical disease is the same across cultures. Although we agree with his first and second propositions, we disagree with his third proposition. Our position is that while physical diseases are 'real' in the sense that they can be identified through material changes in the physical body, they are at the same time saturated with significance and meanings for us. And in just the same way, our subjectivity is such that we struggle to search for meaning and significance in our states of madness and distress. We will show that the difficulty with Szasz's third proposition is that the nature of human subjectivity is such that it is simply not possible to make polarized distinctions between a physically based medicine and the world of culture and meaning. To do this we will first examine the origins of Szasz's ideas about the relation between body and mind, through the work of the French Enlightenment philosopher René Descartes.

Descartes and dualism

We are primarily concerned here with the implications of different forms of dualism for the way in which we experience physical disease, madness and distress. Our analysis is influenced by the work of Hubert Dreyfus (1991). Different types of dualism have figured prominently in Western philosophy for thousands of years, but it is through the Enlightenment and the philosophy of Descartes that we can begin to understand the impact of dualism in contemporary thought. Dreyfus (1991) points out that Descartes' philosophy reinvigorated a tradition

that can be traced back to Plato. In common with many Enlightenment thinkers, Descartes was preoccupied with the problem of knowledge and certainty. He was heavily influenced by Galileo's work in mathematics and astronomy, and he wanted to put philosophy on a similarly secure footing. Could we be as certain of the accuracy and truthfulness of our thoughts about the world as we could be about the solution to a mathematical problem, or the prediction of the positions of the planets? He argued that it was possible to achieve this through reflexive clarity, a systematic reflection on the contents of the mind to distinguish between that which was obviously correct from that which was not, and mapping the ways in which our internal representations of the external world were ordered and related. This principle formed the basis for what subsequently became scientific explorations of subjectivity, for example Husserlian phenomenology, psychoanalysis (as originally conceived by Freud), the origins of the project of modern psychology, especially cognitivism (Bracken & Thomas, 2008), and theories of artificial intelligence.⁹

A central plank in Descartes' philosophy is a belief in the possibility of reflexive clarity, and the importance of defining and mapping the ways in which internal (or mental) representations of the external world are ordered and related. However, a consequence of this is different forms of dualism. These arise as follows: Cartesianism operates on a fundamental distinction between the 'inner' world of the mind and the 'outer' physical world with which it is in contact. This separation of the inner and the outer is predicated upon Descartes' metaphysical (or ontological) separation of the world into two kinds of substance, the soul from the material body in which it resided. The body is characterized by the fact that it possesses 'extension'; it occupies space. It is thus *res extensa* (or a thing that is extended in space). In contrast to this the soul is characterized by thought, and is thus 'a thing which thinks', a *res cogitans*. This view of the self as a thing or substance has had major implications, and two in particular are relevant to understanding the shortcomings of Szasz's arguments. The first of these is the metaphysical notion of two separate substances existing in the world, body and mind. This has given rise to an extensive and on-going debate about the relationship between the two. In addition, there is also the separation of the mind from the outside world that follows in the wake of Descartes' metaphysical dualism. We might call this his 'epistemological dualism',¹⁰ in which the subject is in contact with an outside world and has knowledge of it through sensations that are synthesized and built up into mental representations of the world.¹¹ The point is that in this Cartesian view the mind becomes 'self-contained'. It stands outside the

world and has a relationship to it. Mind ('subjectivity', or our experience of ourselves and the world) becomes something conceivable apart from and separate from this relation. It knows the world from the outside. Thus, there is an epistemological separation of mind from world. It is this epistemological separation, based ultimately, as we have seen, on Descartes' metaphysical dualism, which provides the basis for what is known as the representational theory of mind and thought, concerned as it is with the relationship between inner states of mind and outer states of the world. It is this view of subjectivity that Szasz draws on when he insists that the mental world (metaphysical) cannot be spoken with the language that we use to talk about the natural world (physical), or for that matter that culture and disease are separate worlds.

Embodiment and the philosophy of Merleau-Ponty

Cartesianism has been immensely influential in Western thought. It provides the basis for the scientific view of the world, the idea that it is possible for us to have a detached and objective perspective on the natural world, one that gives us a 'truthful' account of reality.¹² Psychology and medicine have extended this perspective to subjectivity, our bodies and our 'selves'. The mind has become a 'thing' to be studied according to the principles of scientific enquiry, as has the body. This approach has yielded great benefits as far as the treatment of (bodily) disease is concerned, but it has its limitations. Elsewhere, we have used the philosophy of Martin Heidegger to draw attention to these, especially the way in which they fail to account for the way in which our subjectivity is bound to social contexts, is embodied and tied to temporality in a unique way (Bracken & Thomas, 2005). Here, we turn to the philosophy of Maurice Merleau-Ponty to examine in detail the implication of Szasz's ideas about the relationships between body, mind and culture for our understanding of disease and illness. We will use his philosophy to argue that it is simply not possible to separate out physical and mental domains as far as subjectivity is concerned in the way that Szasz suggests. The physical body (biology included) is inextricably bound up with the way we experience ourselves, and the world in which we live. This is especially so when it comes to understanding what happens to us in states of disease, illness and madness. Culture and history play a central role in making this possible.

In *Phenomenology of Perception*, Merleau-Ponty (1962) begins by examining neurological and psychological theories of perception. He is critical of the idea that scientific theories can provide anything like a

complete account of our experience of the world. This is because these approaches to subjectivity fragment it, analyse it and then break it down into different components (mental, physical and so on). Such an approach is partial and incomplete; as Langer (1989: 7) puts it, it is simply not possible to undo the bond between the human subject and the world, and then re-forge it. Merleau-Ponty is not in principle opposed to scientific accounts of experience, but he argues that science itself is derivative and secondary to what he calls pre-objective experience (i.e. our experience of the world as it already presents itself to us).

Merleau-Ponty argues that the starting point for any account of experience must be experience itself. This is because the world of experience is present to us before anything else. For Matthews (2002) this view of phenomenology is part of a tradition that means abandoning a scientific conception of phenomenology in favour of a description of being-in-the-world. Like Heidegger, Merleau-Ponty was concerned not with scientific explanations of experience, but with descriptions of it, so the phenomenological reduction also meant setting to one side scientific explanations and theories.¹³ This aspect of his work has given rise to the view that Merleau-Ponty was anti-scientific, a view that Matthews strongly contests.¹⁴ The human activity of scientific enquiry is itself a product of human experience and history; it involves a very particular way of encountering the world. To achieve this scientific encounter, we systematically strip values from the way in which we 'see' the natural and human worlds. We do this through all the techniques we use to rid science of 'bias'. For example, the language of science does not involve value descriptions such as 'nice, friendly, pleasant, helpful'. But our value orientation to the world is primary and foundational. It is from this context that we have developed the scientific way of understanding. In spite of this, the scientific way of understanding the world is often presented as something that gives us a view of the world 'as it really is'. The irony of biological reductionism in psychology and psychiatry is that it is essentially an attempt to move in the other direction: to use the 'de-valued' language of the physical sciences to explain the value-laden (and 'messy') world of human psychology from whence they sprang in the first place. Scientific accounts of human experience do not stand outside that experience; they are created by it.

Merleau-Ponty points out that phenomenological philosophy means looking at the world afresh. This is because we are so accustomed to a scientific view of the world, our bodies, and ourselves that we take it for granted. This is where we begin to understand why Szasz is mistaken

in claiming that it is only possible to talk about disease through the language of natural science. The scientific view is taken for granted as a foundational and truthful account of reality. This is an objective view, one that sees the world and everything in it, other people and our own bodies included, as objects existing in the world apart from ourselves. The philosopher Thomas Nagel has described this as the 'view from nowhere' (Nagel, 1986). Its objectivity is seen to be free of values. Merleau-Ponty is not opposed to this perspective, but he objects to the idea that it is capable of offering us a complete view of reality. This is because it obscures the fundamental fact that our view of reality is already given through our existence, our being-in-the-world.

An important consequence of this is that our relationship to the world is not one that can be captured through 'inner' representations of external reality such as cognitive schema or information processing, built up through operations on individual sensations or sense data.¹⁵ We cannot grasp human experience as if it were simply a matter of having 'true' thoughts about the world. The world as we experience it does not consist of myriad discrete sensations as the objectivism of science would have us believe, but it is presented to us as a coherent, meaningful (usually) whole. In addition to this, we are physically present in the world through our bodies, so we stand in a closer relationship to it than if we were disembodied pure consciousness. Our bodies place us in a specific place and time, so our experience of the world and our relationship to it cannot be a view from nowhere; it is situated in a specific culture and history. For this reason, Merleau-Ponty's view of phenomenology means that we must accept the cultural and historical realities of human experience. Matthews puts it this way:

If what I am cannot be understood except in terms of my manifold relationships, practical and emotional as well as purely intellectual, with the world that I inhabit, then the phenomenological description of my experience cannot be achieved without reference to my social and historical situation.

(Matthews, 2002: 39)

For this reason we may regard Merleau-Ponty's phenomenology as a hermeneutic phenomenology. It is not possible for us to see the world around us as free of value and meaning.

We have seen that Merleau-Ponty uses the word perception to refer to the nature of pre-reflective experience. In this sense, perception is primary, because the world as we perceive it, as it reveals itself to us

through being as Heidegger might say, provides the basis for all aspects of our experience. The body is vital in making this possible, and for this reason he develops the idea of the body-subject in order to see that the body is so much more than a physiological mechanism, an object reduced to the deterministic rules of physiology and causality. It is the means through which being-in-the-world becomes possible.

The significance of the body-subject

We can begin to understand the importance of the body in Merleau-Ponty's thought through the following extended quote from Matthews:

The world as experienced by a particular subject cannot be a mere collection of independent and merely externally related objects, but must be conceived of as unified by its relations to that subject and his or her projects in it: as a system of meanings. That is the sense in which, for each of us, the world is 'my world'. Thus the subject can be conceived of only in relation to a world, and the world can be conceived of only in relation to a subject. The subject must be 'in the world' both in the way that objects are and in a way that transcends the mode of being of objects.

(Matthews, 2002: 57)

It is through the body that I, as a subject, am 'in the world', and it is through the body that the world becomes open to me. This moves us away from the Cartesian view of the subject as a disembodied mind or brain, something cut off from the world and capable only of a remote relationship with it. Being-in-the-world is only possible because human beings are very special objects in the world. They are living organisms conscious of their environments, and capable of interacting meaningfully with their environments. It is through the body that we act in and on the world in ways that are meaningful for us. We are dependent on our physical senses, given to us by our bodies, for our awareness of our environments.

Burkitt (1999: 75) points out that Cartesianism privileges vision in terms of how we experience the world. He argues that we are more than spectators; our bodies mean that the world is apparent to us through all our senses. We depend on our bodies to move through the environment in order to interact meaningfully with it. This means that any state or condition of the body that impairs our ability to act meaningfully in the world has to be laden with significance.¹⁶ Our brains play a central role

in enabling these activities, and thus having the brains that we have is vital to us being conscious beings in the way in which we are conscious beings.¹⁷ It also means that the body, like other objects in the world, has symbolic meaning. Merleau-Ponty uses the expression *body-subject* to emphasize the unity of experience with the physical basis of the body.¹⁸ This is not to say that we cannot study the body scientifically, and regard it as an object in the world subject to cause and effect like other objects, but the normal way in which we encounter other people is as *body-subjects* like ourselves, or as Matthews puts it, as an expression of other people's way of being-in-the-world. We can no more separate them from their embodiment than we can separate ourselves from our own bodies: 'in this way, the world as we perceive it is again a world of meanings, which include our own bodies and other embodied persons as having particular sorts of meaning for us' (Matthews, 2002: 60).

Body and meaning in disease

Merleau-Ponty's philosophy of embodiment has its limitations. Burkitt (1999) argues that although it sets out a convincing set of arguments for the importance of the body in meaning, it falls short of linking the body properly to the symbolic. Neither does it really engage with the different types of power relationships that have, at different times in history, influenced the body and its role in subjectivity (for example, through the suppression or encouragement of different forms of sexuality). However, while this is beyond the scope of our chapter, we do need to pay attention to the link between the body and the symbolic, because this is central to our arguments about the limitations of Szasz's ideas. At this point we turn to empirical work from medical anthropology that deals specifically with the symbolic meaning of disease and disturbances in bodily function linked to this.

Anthropologists have turned to the concept of embodiment as a methodology that has helped to reformulate theories of culture, self and experience. It provides a way of charting a middle course between body and culture that recognizes the importance of both, and at the same time avoids the pitfalls of dualisms. The anthropologist Thomas Csordas (1994) points out, that embodiment problematizes the distinctions between body and mind, culture and biology, gender and sex. His work (Csordas, 1994a) shows that cultural meaning is an intrinsic feature of embodied experience. He defines embodiment as follows:

Embodiment, in the sense I am using it, is a methodological standpoint in which bodily experience is understood to be the existential

ground of culture and self, and therefore a valuable starting point for their analysis.

(Csordas, 1994a: 269)

There are two issues that require clarification here. The first is the relationship between embodiment and biology; the second is the identification of embodiment as a starting point in preobjective experience, or being-in-the-world. In response to the first, he argues that both biology and culture are forms of objectification (or representation), so it is essential that we move away from our dependence on both, preferably by describing experience in terms of an experiential understanding of being-in-the-world. We can see how he does this through his account of the case of a thirty-year-old Navajo man, Dan, who was a participant in a large-scale study of the illness experiences of Navajo cancer patients. He had been diagnosed as suffering from an astrocytoma affecting the left temporal-parietal lobe. After the tumour was removed he received chemo- and radiotherapy, and developed seizures and a wide variety of neurological and psychiatric symptoms, including headaches and olfactory auras, poor sleep, difficulty expressing his thoughts, blunted affect, disorganized thinking and rambling speech. After surgery he also lost his limited ability to understand Navajo. His attempts to rehabilitate his language skills using word puzzles in magazines were only partially successful.

One evening at an early stage in the post-operative period, Dan had an encounter with the Holy People,¹⁹ which ‘comprised a lengthy auditory experience, followed by a compulsion to talk that relieved his intense headache pain and left him with a “happy and good feeling”’ (Csordas, 1994a: 273). At the time he had this experience his cognitive abilities were still seriously impaired, but his understanding of the event was that this encounter had resulted from a new way of praying, one that was different from the mode of prayer he had learnt as a child. His family agreed. His father (himself a ritual leader) confirmed that, within the cultural tradition, this change in Dan indicated that he would become a healer or medicine man.

Csordas points out that Dan’s problems with verbal fluency made it very difficult for others to understand him, but it was clear that his family and community saw the utterances that arose within the neurological context of his aphasic difficulties as being inspired by the Holy People, but only when Dan stopped trying to fight the aphasia. In other words, his family and community regarded his aphasic utterances as significant and meaningful within the context of their culture. Subsequently Dan participated in four peyote rituals with the elders. These lasted all night, and involved singing, prayer, peyote ingestion and quiet conversation.

In his account of the ritual six months later, he claimed that he had won the support of the elders. Csordas gives three points in support of this. First, Dan claimed that the divine inspiration he had experienced was a consequence of his healing, and that the peyotists should therefore pay attention to what he had to say. Even though part of his 'brain was cut out' (Csordas, 1994a: 275) he had been inspired by the Holy People to speak Holy words. Second, the other participants at the rituals agreed that Dan's prayers must have been correct, because if they had not been so he would have become ill during the rituals, which he hadn't. This indicated within the tradition that his words had incurred divine approval.²⁰ Finally, Dan argued that the reason his words were difficult to understand, especially by the elders in the ritual, was because they reflected in part the concerns of a younger generation of Navajo people, who, like Dan, had moved away and attended college, and had had life experiences that the older generation had not had. According to Dan's account, the elders agreed with this view, and could see that his words were aimed at a younger generation. Indeed, his words helped the elders to understand some of the problems facing their grandchildren. Some were moved to tears by his words. Csordas points out that anthropologists who have worked closely with Navajo peyote rituals see this as an accepted reaction indicating that the participants are deeply moved by a speaker's sincerity.

Dan attached deep significance to the loss of his ability to communicate in Navajo while still being able to speak in English. He concluded that this was because the Holy People wanted him to address young people in English. Most spoke little or no Navajo, and were therefore unable to engage with traditional prayers and rituals, which were part of their heritage. This frustrated them because they were unable to gain benefit from prayer and ritual, but Dan was now in a position to be able to help them with this. Although he had lost what Navajo he had, within his culture and community his illness brought a new meaning and significance into Dan's life, and with it a positive new identity. It formed the basis of his recovery.

Conclusions

Csordas' work, based in the philosophies of Merleau-Ponty and Heidegger, draws out the richness and complexity of experiences in disease and psychosis. We can begin to see how Dan understood and made sense of his experiences, meaning that is suspended between his bodily (neurological) disturbances, his culture and the support and approval of

his family and community. We might say that one of his neurological symptoms, his loss of language, was existentially important for Dan because it also symbolized a wider concern in the Navajo community of the loss of culture and tradition experienced by the younger people. We can see how culture and community carry and validate the meaning of Dan's experiences, which otherwise would simply be seen in terms of neurological or cognitive deficits. More than that, we can see how, as a result of placing Dan's experiences within a spiritual framework shared with his community, he emerges with a positive identity, one that gives him a unique and significant role in helping a younger generation of Navajo. In other words we can begin to see how culture and meaning interact with biology and identity to bring about the conditions that are necessary for the emergence of recovery.

Seen in this light, the dualism that characterizes Szasz's ideas is not only theoretically problematic, but it just does not make clinical sense. David Pilgrim (2007) points out that grounds for questioning the scientific basis of psychiatric conditions are also applicable to many physical disorders. Many chronic physical conditions, especially those encountered in primary care, such as arthritis, psoriasis, irritable bowel syndrome and asthma have no clearly established aetiology and low treatment specificity. Szasz pays no heed to this.²¹ All these conditions have psychological and cultural dimensions as well as a physical basis; if doctors fail to engage with all three of these then they are failing to engage properly with patients. The importance of this emerges in the work of Daniel Moerman, an anthropologist who has devoted his academic life to studying what he calls the meaning effect in medicine. Much of his work deals with the placebo response, which he prefers to call the meaning response. He draws attention to many studies that show how the formal properties of placebos, such as their colour, and whether they are in tablet, capsule or injection form, influence their potency. He also cites studies that show that sham surgery is effective in relieving symptoms, such as operations for angina (sham internal mammary ligation), pacemaker implantation, laser treatment for severe angina, as well as surgery for prolapsed intervertebral discs and Meniere's disease. In summarizing these studies, Moerman makes the following point:

Much of the meaning of medicine, of the meaning response (and in the narrowest sense, the placebo response), is a cultural phenomenon engaged in a complex interplay of the meanings of disease and illness. The modern triumph of a universalist biology tends to blind us

to the dramatic variation in the ways that people experience their own physiology based on who they are and what they know.

(Moerman, 2002: 70)

The key issue, we suggest, is that medicine has struggled with dualism since Descartes. We are so deeply accustomed to thinking about ourselves as human beings in terms of either the body or the mind, and at the same time locking culture outside in the cold, that as doctors we have to resort to philosophically suspect and clinically awkward concepts such as 'psychosomatic' medicine to bridge the gulf. It follows from our analysis that misery is not in need of de-medicalizing; instead it requires a different type of medicine, one informed by insights to be gleaned from existential phenomenology. For a brief period there was a tradition in European psychiatry and philosophy that showed that this was possible. Sadly, the work of Ludwig Binswanger, Eugene Minkowski and others, which was brought to the attention of the English-speaking world by May et al. (1958), lies buried beneath the fallout from the polarized arguments of Szasz and his followers, crushed by the evidence-based Behemoth that psychiatry has become. We should not de-medicalize misery, but instead try to answer the question that Rollo May (1958a: 3) poses: 'can we be sure ... that we are seeing the patient as he really is, knowing him in his own reality; or are we seeing merely a projection of our own theories about him'?