

designated as having mental disorders. There needs to be a transparent debate about when it is justifiable to subject someone to forcible confinement and mind-altering interventions. Crucially, the verdicts of people who have experienced such measures need to be heard. As Szasz identified, however, this is unlikely to happen as long as these conditions are defined as medical illness and intervention as 'medical treatment'. A system is possible, however, which reduces the gap that sometimes exists between freedom and sanity.

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# The legacy – or not – of Dr Thomas Szasz (1920–2012)

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**Dr Trevor Turner was asked to provide a commentary on the preceding paper in this issue, “Freedom is more important than health”: Thomas Szasz and the problem of paternalism’, by Joanna Moncrieff.**

During the 1960s and 1970s the arguments put forward by Thomas Szasz, a Hungarian émigré who established himself in the psychoanalytic world of the USA, becoming Professor of Psychiatry at the State University of New York in Syracuse, were widely discussed and even admired. His arguments, made most forcefully in his 1961 book *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, essentially stated that psychiatry was an emperor with no clothes. He considered that physical health could be dealt with in ‘anatomical and physiological terms’, while mental health was inextricably tied to the ‘social’ (including ethical) context in which an individual lives. He regarded the term ‘mental illness’ as a metaphor, and used the analogy of a defective television set to explain his meaning. It was as if, in his view, a television viewer were ‘to send for a TV repair man because he dislikes the programme he sees on the screen’.

As outlined in the previous article in this issue, by Joanna Moncrieff (2014), Szasz held freedom to be more important than anything, seeing psychiatrists as paternalistic and imposing a myth on capacious individuals whom they deem to have a ‘mental illness’, but who are actually suffering from degrees of social deviation rather than a formal disorder. He wrote numerous articles and books, and was popular at meetings. In the early 1990s, at a meeting of the European Association of the History of Psychiatry, he was quite charming, impervious to argument, and a little hard to understand because of his unique accent.

Szasz’s views over the 30 or 40 years of his working life never changed, the patient being someone who paid you money to receive discussion and advice. He worshipped at the throne of the contractual life, denying schizophrenia’s illness status, there being no organic factors. Detention under the Mental Health Act he saw as a threat to individual liberty, not a therapeutic event. Patients seeking help from psychiatrists he found perplexing. The logic of his view, therefore, would see Parkinsonism (when first described in the 19th century) as a non-disease, it being just a description of behaviours rather than linked to physical pathology. Martin Roth (1976) gave an excellent critique of his theories.

What did emerge from the antipsychiatry movement was the realisation that psychiatry needed to get its diagnostic house in order. The development of stricter criteria for defining schizophrenia, led by the World Health Organization, established a most reliable diagnosis. Perversely, this move away from the more psychoanalytic versions (of schizophrenia and hysteria, for example) to the first-rank and functional criteria of the modern period reduced psychiatry’s standing in the artistic and intellectual worlds. The psychotherapeutic doctor hero (Szasz, even?) in many 1960s and 1970s films has now become the white-coated figure in a secure unit, injecting people and giving them shock therapy, and even the ultimate psychiatric monster, Dr Hannibal Lecter (an ultra-Szaszian version of how he portrayed psychiatrists).

In her commentary on Thomas Szasz’ work, Dr Moncrieff has suggested that ‘Only when healthcare is designed and implemented by the community itself will it be able to foster the development of capable and autonomous individuals’. This view is quite Szaszian, in denying the specialist skills of psychiatry. But while, for example, a

diabetic patient after 10 years of illness may know much about both his symptoms and his treatment needs, the extraordinary debate in the USA about health insurance for everyone (not just the rich) and the shooting of vaccination workers in Pakistan seem to indicate that 'sensible' beliefs about healthcare are not necessarily the norm. We do have intense debates about mental health in the UK (e.g. the 10-year discussion around a new Mental Health Act, an admirable social construction), and the battle against stigma is long and wearying.

Whatever psychiatry is, it is clearly a part of medicine in terms of taking a history, examining patients and reaching a diagnosis to provide

treatment, and can be seen as one of the most thoughtful parts of medicine. Everyone has a right to treatment, the best available, and detained patients rarely take umbrage once they become well. Dr Szasz has had his time, and paying him privately is not (in my view) the way to construct modern doctor–patient relationships.

## References

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## NEWS AND NOTES

Contributions to the 'News and notes' column should be sent to [ip@rcpsych.ac.uk](mailto:ip@rcpsych.ac.uk)

### Turning the World Upside Down

'Turning the World Upside Down' is a project that aims to provide a forum for health workers in low- and middle-income countries around the world, in which to share experiences, case studies of good practice and innovation. One of the project's themed competitions – the 'Mental Health Challenge' – sought examples of approaches to mental health in low- and middle-income countries which could be used in high-income countries. This competition culminated in a showcase which was held in November 2013 and chaired by Lord Nigel Crisp. Four case studies were presented, including a telepsychiatry service run from a bus in Kerala which connects to mobile technology, and the winning project: the 'Dream-A-World Cultural Therapy' (DAW CT) programme in Jamaica. Led by Professor Hickling, DAW CT is a multimodal intervention for high-risk primary school children, which fosters impoverished children's creativity to boost their academic performance, self-esteem and behaviour. All 34 case studies submitted to the Mental Health Challenge competition can be viewed on the 'Turning the World Upside Down: Mental Health' website (<http://www.ttwud.org/mentalhealth>).

### Diaspora conference – Academy of Medical Royal Colleges

In November 2013, the Royal College of Physicians hosted a diaspora conference for the Academy of Medical Royal Colleges with the theme of 'models of collaboration between medical diaspora and professional medical organisations'. The meeting reinforced the value of the work of these organisations and collaboration between them at a professional and personal level, with benefits both in the UK and overseas. For instance, advocacy work is enabling UK-based volunteers to be released more easily from their work commitments with the National Health Service, and the Medical Initiative Training Programme is underway to allow doctors from overseas to get training

experience in the UK. The event also highlighted the need for psychiatrists to engage with Health Education England and equivalent bodies in the UK countries.

Over 30 medical diaspora organisations were in attendance and several of these demonstrated their work in their home countries; there were some remarkable presentations on exciting projects and a masterful poster session. Mental health was well represented, with projects from diverse locations such as Uganda, Latin America and Iraq. For instance, the Zambia UK Health Workforce Alliance (ZUKHWA) is a network of UK-based groups who have united with Zambia-based organisations to support the Zambian government; this model is also being developed in Uganda. There was a lot to learn from the collective experiences on offer at the diaspora conference and there are plans to develop the ideas formulated there and to synergise the work that was exhibited on the day.

### UK-Med

The UK has formalised its system for sending humanitarian volunteers to disasters around the world. In the past, there has been a lack of co-ordination during humanitarian crises but now UK-Med has developed a UK International Emergency Trauma Register.

The register brings together healthcare practitioners with a range of skills and talents from all areas, including mental health professionals, paramedics, nurses and surgeons. All members on the register will be trained and once they have gained some experience they can be deployed for 2–3 weeks when a major international catastrophe occurs, at just 24–48 hours' notice. More information is available on the UK-Med website (<http://www.uk-med.org>).

We value feedback and contributions for news and notes. We also welcome any comments on current international issues in mental health