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REALISM AND ANTI-REALISM IN THE PHILOSOPHY OF PSYCHIATRY[1]

SUMMARY: *This paper invalidates the anti-realist point of view on the existence of mental illness by reviewing the anti-psychiatry challenge to official psychiatry. We present the anti-realist ideas of Thomas Szasz as the most radical anti-psychiatric author followed by the more moderate thoughts of Cooper and Laing. We then present the criticism of all these authors, most notably by the Canadian philosopher of psychiatry L. Reznek. We argue that some forms of schizophrenic experience can be non-pathological and emancipatory, but that this does not negate the existence of schizophrenia as a mental illness. After the invalidation of the anti-psychiatric point of view that insanity is just a political construct, mental illness is defined as not only a biomedical, but also a semiotic reality. Finally, we differentiate the object-level and the meta-level of the problem of anti-realism in psychiatry and conclude that anti-realism is only acceptable on the former level, as a characterisation of the lack of reality testing by psychiatric patients.*

KEY WORDS: *anti-psychiatry, schizophrenia, rational strategy, pathological reality, biochemical process, semiotic dissonance.*

As a social movement and a theory, anti-psychiatry was founded in the 1960s. The term itself was introduced by the South African psychiatrist David Cooper, who, along with British psychiatrist Ronald Laing and American philosopher of psychiatry Thomas Szasz, played the greatest role in articulating the theory of this movement. Even though it is a heterogeneous set of ideas, it cannot be denied that a particular kind of anti-realism is the basic characteristic shared by all the proponents of anti-psychiatry. The topic of this critical overview is the anti-realist challenge to psychiatry as a medical discipline, which was formulated in the most radical terms by the anti-psychiatrists.

Long before the anti-psychiatrists, the German psychiatrist and philosopher Karl Jaspers wrote on the paradoxicality of the term "mental illness" in the sense that the general notion of illness implies a kind of lack, whereas mental illness

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often implies an individually desirable excess, i.e. a talent and superiority in comparison to mental normality.[2] However, the most radical anti-psychiatrist, Thomas Szasz, goes even further, saying that mental illness does not exist[3] and that the vocabulary of psychiatry is full of fiction, mythical content and empty symbolism, which serve government repression against those individuals who manifest politically undesirable modes of behaviour. According to him, "the principal problem in psychiatry has always been, and still is, violence: the threatened and feared violence of the "madman" and the actual counter-violence of society and the psychiatrist against him. The result is the dehumanisation, oppression, and persecution of the citizen branded "mentally ill"... The best, indeed the only, hope for remedying the problem of "mental illness" lies in weakening – not strengthening – the power of institutional psychiatry".[4] This point of view implies that psychiatry has no actual object of research and therapeutic treatment independent of itself, but that its essence lies in manufacturing, rather than discovering and eliminating, the states it deals with. Therefore, the belief here is that mental illness is only politically, but not medically and scientifically real, or even real in the strict sense of the word. This belief possesses the features of epistemological anti-realism.

The case is similar with the beliefs of other classical proponents of anti-psychiatry. Cooper, for instance, claims that "biochemical theories of the cause of schizophrenia must of necessity (however far biochemical technique may advance) fall short of their stated goal of causal explanation",[5] while Laing, in his conversation with Richard Evans, points out that „none of the great studies mentioned in textbooks offer scientific proof for the so-called genetic theory of schizophrenia".[6] These authors do not doubt that mental disorders have organic correlates, but they believe that those correlates are the consequences and not the causes. According to them, the etiology of schizophrenic psychosis is not to be found in endogenous organic processes, but in social interaction and the dynamic of family relations, i.e. in the violence of the family and the society against the individual, and the individualfs personal response to this violence. As with Szasz, this implies the anti-realist thesis that psychosis, at least the schizophrenic type, is not a biomedical reality in the primary sense, but a socially induced artificial state, i.e. a social construct which is to be deconstructed through the rearrangement of psychiatric institutions and the de-medicalisation of the societyfs attitude towards psychotic individuals.

2 See: K. Jaspers, *Opšta psihopatologija*, Beograd, 1978, str. 734.

3 See: T. Sas, *Mentalna bolest kao mit*, Beograd, 2008, str. 11.

4 T. Szasz, *Proizvodnja ludila*, Zagreb, 1982, str. 14.

5 D. Cooper, *Psihijatrija i antipsihijatrija*, Zagreb, 1980, str. 20. As a paradigmatic form of psychosis, schizophrenia is the favourite topic of the anti-psychiatrists.

6 R. Evans, *Graditelji psihologije*, Beograd, 1988, str. 255.

However, the essence of the anti-psychiatric school of thought cannot be reduced to the idea that the environment or society has primacy over the hereditary factor in the development of mental disorders. According to Cooper, "reductive analyses, whether these be framed in terms of physiology, learning theory, or psycho-analytic theory, may very completely and in detail portray the extra- and intra-organismal background against which the person stands, but in each case, and for the same reason, the personal reality itself is omitted. In each case the reductive approaches we have mentioned end in a specifically interrelated aggregate of inert totalities".[7] Anti-psychiatry was greatly influenced by the phenomenological-existentialist idea about the constitutive role of the subjective consciousness and choice in structuring an objective state of things, which is why all of its proponents emphasise the crucial role of the individualfs personal attitude towards the facts of life in the process of developing what is referred to as mental illness. Since schizophrenia is ultimately a matter of personal choice of onefs own strategy for self-liberation, i.e. for coping with lifefs problems – rather than an organic process – the anti-psychiatrists believe that schizophrenic individuals may benefit a lot more from conversation with a philosopher or priest or from non-medication psychotherapy than from traditional medical-psychiatric treatment.

Canadian philosopher of psychiatry Lawrie Reznek, among others, reacted to the anti-psychiatry challenge by defending biomedical realism regarding mental illness. According to his definition, „something is a (mental) illness if and only if it is an abnormal and involuntary process that does (mental) harm and should best be treated by medical means".[8] Unlike the anti-psychiatrists, he believes that there is always an organic basis to all mental illness and that genes are the true cause of schizophrenic psychosis, while abnormal family situations only speed up its development.[9] As for the state of abnormality, he does not deny that it is a social construct conditioned by the conventional definition of mental normality. However, he does not think this implies utmost cultural relativism and non-scientific contextualism.[10] Reznek explains that the fact that something is a social construct does not mean that the entity referred to does not exist independently of the construct itself, and believes that scientific objectivity is consistent with theoretic convention. To

7 D. Cooper, *Psihijatrija i antipsihijatrija*, str. 14.

8 L. Reznek, *The Philosophical Defence of Psychiatry*, London, 1991, p. 163

9 See: Ibid., p. 64.

10 In his critique of Habermas's hermeneutic philosophy of psycho-analysis, American philosopher Adolph Grünbaum demonstrated that contextualism is not a specific trait of the humanities and that historical context is also very important for natural sciences, meaning that historical contextualism and the scientism of the natural sciences are not mutually exclusive. See: A. Grünbaum, *The Foundations of Psychoanalysis*, Berkeley/Los Angeles/London, 1984, pp. 15-21.

him, what makes mental illness a universal phenomenon – and an entity independent of social convention – has to do with the direct connection between mental suffering and involuntary bio-chemical processes, which is evidenced by the high success rate of medication therapy in the treatment of mental disorders. In other words, Reznek argues that even if abnormality is a construct, involuntary bio-chemical processes present in the case of mental illness are certainly not.

In Reznek's view, only abnormal behaviour caused by biological dysfunction in the brain may be termed mental illness. This separates mental illness from the forms of abnormal behaviour not caused by illness – such as criminal behaviour – on the one hand, and from physical illness on the other (metal illness means dysfunction of the so-called higher mental functions located in the brain, while physical illness means dysfunction of physical organs in a narrower sense). Of course, it is possible that some states may be incorrectly identified as mental illness, but, according to Reznek, incorrect identification is rare thanks to the fact that psychiatry uses scientific methodology. In his opinion, psychiatry is a true science, because its object of study is real and because it formulates empirically verifiable hypotheses about its object of study and offers causal explanations and wellfounded theoretical predictions. The effectiveness of psychiatry in therapy justifies its causal explanations, because mental illness can only be cured if its true cause is eliminated, and this cause – as confirmed, according to Reznek, by the positive effects of pharmacotherapy – is bio-chemical dis-balance in the brain.

So, Reznek bases his defence of medical-scientific realism in psychiatry on the differentiation between outward manifestations and the true causes of mental illness. He believes that abnormal behaviour, as the external aspect of mental illness, may be a social construct and a theoretical convention, but that the same cannot be the case with the bio-chemical causes in the central nervous system. According to this idea, however one defines normal and abnormal behaviour, these definitions are just one segment of psychiatric theory and they carry far more significant explanatory and prognostic content. However, once the psychiatric scientific community has reached a consensus on the definition of "abnormal", this definition becomes mandatory – at least until a new convention is adopted – and has an important role in diagnosis. Reznek, controversially, has this to say on the subject; "Whether people are really hallucinating when so judged does not really matter. If we can reliably detect abnormal (verbal or non-verbal) behaviour, [it can be said that] psychiatry has a satisfactory observational base".[11]

In his reconstruction of Laing's attempt to "rationalise insanity", Reznek finds the essence of this anti-psychiatric theory in the view that if the schizophrenic patient's abnormal behaviour is governed by a rational strategy, its cause cannot be

11 L. Reznek, op. cit., pp. 186-7.

mental illness, nor can schizophrenia be reduced to mental illness. [12] Unlike Laing, Reznek indicates that the contrast between rational-mentalist and causal-physicalist explanations is a false dilemma, because the effective power of psychological reasoning is based on neurophysiological processes. In other words, Reznek subscribes to the theory of psycho-physical identity, which sees the abovementioned types of explanation as merely two different ways of linguistically and logically articulating the same process. In his opinion, rational thinking does not necessarily imply mental health (as Laing and his philosophical role-models believe) – it may also have a pathological bio-chemical basis, i.e. a psychological function. This theory insists that in order to understand the nature of mental illness, it is much more important to perceive the connections between external behaviour and the internal bio-chemical processes in the brain than to follow the philosophical custom of seeing insanity as the loss of reason, i.e. a problem in the internal flow of thought. Therefore, the attribute „involuntary" in Reznek's definition does not mean the absence of conscious desire in the individual believed mentally ill. It has to do with the spontaneity of the basic neurophysiological processes, the pathological status of which has nothing to do with subjective beliefs and desires.

In a recently defended and published doctoral thesis on the philosophy of anti-psychiatry,[13] Serbian philosopher Dejan Đorđević criticises the metaphysical pretensions of both the Szasz type of anti-realism and Reznek's realistic viewpoint. In both of these he recognises a susceptibility to the metaphysical temptation to cross the boundaries of empirical knowledge by being too quick to commit the logical errors of generalisation (*fallacia fictae universalitatis*) and taking the part for the whole (*pars pro toto*). Đorđević explains that the fact that mental illness is in some cases a mere label caused by incorrect identification does not and cannot mean that mental illness in general does not exist (as Szasz thinks). He also says that the fact that some forms of schizophrenic experience are based on pathological bio-chemical processes does not justify the general categorisation of schizophrenia as a mental illness (as Reznek believes). According to Đorđević, exclusivity of any kind is unacceptable in the philosophy of psychiatry, which is best illustrated by the case of schizophrenia: some of its forms can be categorized under Reznek's definition of mental illness, while others represent emancipatory breakthroughs of the personality or a mystic transformation of onefs own consciousness as per Cooper's and Laing's ideas. The theoretic background of this idea is ontological-methodological individualism, which states that every concrete (pathogenic or non-pathogenic) mental state should be approached as a unique and nomically irreducible mental event. It implies the abandonment of the deductive-nomological model of scientific explanation to which Reznek was unconditionally loyal.

12 See: Ibid., p. 54.

13 D. Đorđević, *Uvod u filozofiju abnormalnog,* Beograd, 2010.

Russian philosopher Vadim Rudnev notes that the main characteristic of the anti-psychiatric movement is the fact that its, "basic pathos was an apology of the schizophrenic consciousness, an attempt to demonstrate that schizophrenics are not ill, but that their consciousness is organized differently, maybe even far superior to the so-called normal consciousness".[14] Furthermore, Rudnev examines anti-psychiatry in the context of the dominant trends in 20th century culture, noting that anti-realism, a kind of abandonment of reality, is the main characteristic of contemporary culture – unlike the realist culture of the 19th century, which was dominated by the natural sciences. According to Rudnev, this anti-realist culture is manifested through the schizophrenic way of experiencing the world – widespread among the people of today – through various forms of simulation, i.e. the loss of external reference points. However, even though, like Jaspers, he notes that, "a total absence of insanity ... is also a kind of pathology – *normosis*",[15] Rudnev does not believe that schizophrenia in the narrow sense is a state superior to the non-schizophrenic realistic consciousness, because the quality of life depends on the quality of communication, and successful communication depends on good contact with reality.

To Rudnev, the essence of schizophrenia as a paradigmatic form of insanity lies in the disharmony with reality, i.e. the lack of reality testing, while he defines normality as a, "harmony between things and words, between facts and the statement of facts, between the signified and the signifier".[16] In his opinion – which is heavily influenced by Wittgenstein and Quine, but also by Lacan – the psychotic disharmony with reality is actually disharmony with semiotic reality, because reality is always shaped linguistically and inter-subjectively. In that sense, Rudnev insists that, gschizophrenia is a disease of language, corruption of language, abuse of languageg,[17] and, in the spirit of Wittgenstein's idea of private language, sees it as self-isolation and departure from public communication. This viewpoint differs greatly from the views of both the anti-psychiatrists and Reznek. On the one hand, Rudnev does not consider mental illness a myth, nor does he characterise schizophrenia in a positive way. On the other hand, he does not define mental illness as biomedical, but as linguistic pathology. For that reason, Rudnev favours what he calls semiotherapy over medication therapy.

What can we conclude about realism and anti-realism from the opposing views presented above? Firstly, in the philosophy of psychiatry we should differentiate between the object-level and the meta-level of examining the connection to reality.

14 В. Руднев, *Диалог с безумием*, Москва, 2005, стр. 117.

15 Ibid., стр. 61.

16 Ibid., стр. 170.

17 Ibid., стр. 135.

On the object-level, unreality as the absence of reality testing in psychiatric patients is one of the most important characteristics of psychiatric phenomena. The meta-level, however, questions the reality of mental illness itself, i.e. it problematises its ontological and epistemological status and examines its type of reality. Secondly, the anti-realism of the anti-psychiatrists has to do with the negation of the biomedical and pathological nature of schizophrenia or so-called mental illness in general, rather than the negation of all of its types of reality. Anti-psychiatrists do not claim that insanity does not exist; they believe it does not exist as an illness – as bio-pathological reality – but as social and political reality and a rational existentional strategy. Thirdly, the existence of cases of incorrect identification of mental illness does not mean that there are no cases which can be rightfully categorised as mental illness. Schizophrenic experience in the broader sense need not be an illness – it can be a mystic experience or an emancipatory outburst of creativity – but schizophrenia in the narrower sense does exist as an illness. Finally, the fact that there are true cases of mental illness does not mean that the reality of mental illness is necessarily biomedical in character, because at least some of its forms are primarily connected to semiotic reality, i.e. to the pathology of verbal communication. Reductive neurophysicalism regarding mental illness is unjustified, because some forms of mental illness demand both description from the first person perspective and semiotic analysis. Although neurophysicalism is the superior position ontologically, it is not superior in the linguistic-descriptive sense.

All of these individual conclusions allow us to make one general conclusion: anti-realism in the philosophy of psychiatry is acceptable only as a characterisation of the psychiatric patients' connection to reality, while on the meta-level realism – both biomedical and semiotic – is the superior theoretic viewpoint.

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Realizam i antirealizam u filozofiji psihijatrije

(Apstrakt)

U radu se pobija antirealističko stanovište u pogledu pitanja o postojanju mentalne bolesti, kroz razmatranje antipsihijatrijskog izazova zvaničnoj psihijatriji. Najpre se izlažu antirealističke ideje Sasa, kao najradikalnijeg antipsihijatrijskog autora, Kupera i Lenga, kao nešto umerenijih mislilaca. Zatim se iznose kritike na njihov račun, pre svega od strane kanadskog filozofa psihijatrije L. Rezneka. Zastupa se teza da neki oblici shizofrenog iskustva mogu imati nepatološki i emancipatorski karakter, ali da iz toga ne sledi da ne postoji i shizofrenija kao mentalna bolest. Pobijanje antipsihijatrijskog shvatanja da je ludilo prazan politički konstrukt, praćeno je određenjem mentalne bolesti ne samo kao biomedicinske, nego i kao semiotičke realnosti. Na kraju se pravi razlika između objekt-nivoa i meta-nivoa problema antirealizma u psihijatriji, i zaključuje se da je antirealizam prihvatljiv samo na prvom nivou, kao karakterizacija nedostatka testiranja realnosti kod psihijatrijskih pacijenata.

KLJUČNE REČI: antipsihijatrija, shizofrenija, racionalna strategija, patološka realnost, biohemijski proces, semiotički nesklad