Four Assumptive Worlds of Psychopathy V: The World of Mental Illness

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As I suggested in the first essay in this series, our understanding of the four assumptive worlds of psychopathy can be informed by the differentiation to be made between paradigms, models and practices (the categorization developed by David Halliburton and myself). I suggested that assumptive worlds are composed of a few, very powerful paradigms, and a small cluster of models. Furthermore, the models are often borrowed from other fields—and as a result of this often-indiscriminate borrowing there are often untested and even inappropriate elements of the other field brought with this field.

We have seen this vividly demonstrated in the borrowing of theology and church dogma in the first assumptive world (spiritual aberration), the borrowing of spiritual, philosophical and cultural elements in the second assumptive world (distribution of energy, fluids and functions) and, finally, the borrowing of elements from the fields of sociology, history, sociopsychology and social criticism in the third assumptive world (social deviation).

This borrowing is even more poignant and pervasive in the fourth assumptive world. We observe an important shift from the social/political system in our third assumptive world to the medical system in the fourth world. With this shift comes the application of many medical terms, perspectives and treatment modalities to the domain that is now called "mental illness." While there are many ways in which psychopathy has been confiscated by the world of medicine, I will focus on four major elements:

(1) the shifting to an external locus of control (we can usually trace psychopathy to a physiological dysfunction—often neurological in nature), with a secondary emphasis on internal locus of control (poor health habits)
(2) the belief that specific forms of psychopathy can readily be categorized (diagnosed) in a manner that leads to specific treatment strategies
(3) the effective treatment of specific psychopathologies usually requires a medical (typically pharmacological) intervention, and
(4) the payment for treatment is increasingly being aligned with medical reimbursement policies ("mental illness" is "covered" under a medical insurance plan or government-based financial support for "medical services.")

The Etiology of "Mental Illness"

As I noted in the first essay, words do seem to matter in the social construction of reality. They matter in terms of both semantics (meaning of words) and syntax (ordering of words). In embracing the term "mental illness" most contemporary societies are creating an important and powerful new construct: psychopathology is in most instances a form of illness (like cancer or diabetes) that is caused by some physical pathogen, genetic defect or injury to the body (and in particular to the brain). This shift to a focus on something other than spiritual aberration or social deviance is certainly to be commended as a way of looking for sources outside the church or penal code. Furthermore, this fourth assumptive world has produced very detailed and scientifically based descriptions of how mental illness is produced. Certainly, most societies are doing a much better job of "curing" psychopathologies under the banner of this fourth assumptive world than was the case with either the spiritual or societal worlds.

In recent years, we are even seeing an interesting and often productive interplay between the second world (especially the Asian version) and the fourth world. Often under the title of "complementary" medicine, we see the use of meditation, mindfulness and yoga practices being "prescribed" by medical doctors and physicians for their patients who are struggling with emotional and mental problems. While this complementary (and complimentary) relationship often does not include acceptance in Western medicine of the Asian assumptions about the sources of psychopathology, there is ample use of the health-inducting practices and treatment strategies that arisen from the etiologies assumed by this Asian world. I would also note that the word "complementary" may be very important here.

In my own previous co-authored book on medical cultures (*Who is Wounding the Healers*) (Bergquist, Guest and Rooney, 2004), we pointed out that the term "alternative" was being used for many years to describe a cluster of medical and nonmedical concepts and practices that were posed in contradiction to the accepted (allopathic) medical concepts and practices. It was assumed that these "alternative" perspectives were to be corrective on or even replacements for the dominant medical theories and practices.

A somewhat unholy alliance was established late in the 20th Century that enabled alternative practices and practitioners (at least in the United States and Canada) to be accepted (with some reservations) within the fold of established medicine—thereby enabling practitioners to receive compensation from an insurance company or government rather than relying on direct payment from the customer ("patient"). Unfortunately, payment for this admission to the medical community was an abandonment of the term "alternative" and acceptance of the term "complementary" (suggesting that these alternative practices are

to still be considered secondary to traditional allopathic medical principles and practices). Yes, words do matter.

What does all of this mean? We can turn back to our references regarding syntax in the first essay. Most Western languages are right branching (and reliant on active voice). This manner of syntactic structure tends to highlight internal locus of control: “the boy hit the ball”. The primary agent is the boy. The ball is secondary. “This crazy person is a sinner and deserves to be suffering!” “This prison keeps social deviants in chains!” Agency is clearly identified in both of these sentences: the crazy person and the prison. The first and third assumptive worlds are both very clear and consistent about the source of psychopathological behavior. An alternative agent has been identified in the case of our first assumptive world (Satan evil doings or God’s predestination plans); however, the agency is still clear and consistent.

When we turn to the second and fourth assumptive worlds there is less clarity and consistency. The primary agency is usually assumed to be some pathogen, genetic factor or injury—yet healthy practice and other preventative measures are still emphasized. We are victims of “mental illness”, but in some instances can do something to ameliorate or even prevent this illness. This ambiguity regarding etiology is exemplified in recent emphasis on determining the percent of mental illness (such as depression, bi-polar disorders and schizophrenia) that can be attributed to generic predispositions (nature) rather than environmental factors of behavioral patterns (nurture).

The syntax itself reflects this ambiguity. We often say something like the following” “mental illness has afflicted this unfortunate person.” We focus on the pathology (schizophrenia or depression) rather than the person—a “schizophrenic” forfeits all other identifies. As we noted with regard to “stigmas” when entering the third assumptive world, the world of “mental illness” is filled with stigmatizing terminology: while we are trying to remove the blame from those “allected” with a mental illness, we also are inclined to believe that this is a permanent affliction that can be controlled with medications, but never “cured.” There is no healing grace coming from a benevolent God, nor any spiritual practices that bring about a rebalancing of the body’s energies, nor any release from prison or poverty. There is only a lifelong, isolating “affliction.”

The Categorization of “Mental Illness”

By defining psychopathology as a form of “illness”, leaders of a society and, in particular, leaders of the medical community, can provide a rationale for the belief that specific forms of psychopathy can readily be categorized (diagnosed) in a manner that leads to specific treatment strategies.

If we can determine that a leg is broken, an appendix is burst, or a heart is malfunctioning, then we should also be able to identify specific maladies that are mental and/or emotional.

We should be able to differentiate between (and isolate) specific forms of psychopathology. In fact, we have done just this in the Western world. A formal categorization has been formulated by the American Psychiatric Association (not the American Psychological Association). This is the Diagnostic Statistical Manual—which is now in its fifth edition and is fundamental to the diagnosis and categorization of "mental illness."

I will have much more to say about DSM in the sixth essay and will be ably assisted in this description and analysis by several colleagues in the graduate school where I serve as president (The Professional School of Psychology). At this point, let me just note that DSM has a very broad, global reach.

DSM not only strongly influences (even determines) third party payments in the United States and some other countries (including those providing government funding of psychiatric and psychological treatment). It also has become a firmly enforced social construction in many of the human service fields (including not just psychiatry and psychology, but also such fields as social work, school counselling and pastoral counseling). This enforcement includes a requirement that old versions of DSM be destroyed, since they no longer provide the "truth" about psychiatric categorization. It was even suggested that these manuals be "burned" so that someone unsuspectingly would pick up an outdated version at their local dump and be misguided in their use of this manual.

As we will report more fully in our sixth essay, the battle over the constructs established in a new version of DSM is often waged with great passion (and a substantial amount of politicking, marketing and expenditure of funds by pharmacological, medical and allied health institutions). Issues related to societal biases regarding classification of sexual orientations (such as homosexual and transgender) and specific asocial behaviors (such as aggression and sexual promiscuity). Should any of these orientations or behavior patterns be considered "mental illnesses"? We know that having a heart attack is a bad thing. What about being Gay or verbally abuse or paying for (or providing) sexual services? Are these signs of being "crazy."?

At this point; the third and fourth assumptive world converge (or collide): when does a medical model replace a model of social deviance? When does the management of power transfer from the courts, prisons and asylums of a society to the wards of hospitals and offices of insurance company executives or government officials? Who is best qualified to identify and classify psychopathy: the doctor or the legislator? We will have much more to say about these important issues in our next essay. Now on to the

choice of interventions, that are clearly influenced by the classification that is made regarding a specific psychopathy.

The Treatment of "Mental Illness"

There is the famous old saying: "if all you have is a hammer then you will treat everything as a nail!" From a very similar (though reversed) perspective, we would suggest that if your assumptive world is saturated with medical imagery and language, then you are likely to offer treatments that are medically oriented. Psychopharmacology is the most obvious of the medical "hammers" to be deployed. We can also turn to medical procedures that are much more intrusive (and sometimes curative): such as electroconvulsive therapies and lobotomies.

In a more preventive mode (and in closely alignment with our second assumptive world), we can point to various Western strategies for the "healing" of "mental illness". These often involve the "big three": nutrition, sleep, and exercise. In many cases, these more benign procedures were first introduced in Western societies through the "osteopathic" and "chiropractic: branches of medicine and in other branches of what I have already identified as "alternative medicine."

These practices are becoming more "mainstream" (as I noted above) and have been re-identified as "complementary medicine." Regardless of their name, these practices have proven to be of great benefit in both the prevention and amelioration of certain psychopathologies. We may find that this "healthier" branch of contemporary psychiatry and psychology will become increasingly influential—yet remain under the general purview of the fourth assumptive world (with some nodes in the direction of the second assumptive world).

When we turn to the role played by the fourth assumptive world in Asian societies, there is extensive interweaving of practices from the world of medicine with the practices embraced by the second assumptive world. Procedures such as acupuncture and the application of healing stones and crystals reflect a more hammer-like application of Asian medicine (often interwoven with Western alternative practices) to the treatment of many physical and mental "illnesses". Other procedures such as meditation, mindfulness and the martial arts enter as purer expressions of the second assumptive world.

Clearly, the reframing of psychopathy as "mental illness" has led to significant improvement in the treatment of such forms of psychopathy as schizophrenia and bi-polar disorders. Medications have been of great benefit to men and women suffering from sustained anxiety, and to those struggling with phobias and obsessive-compulsive disorders. Perhaps of greatest importance is the recognition that medical treatments (such as medication) should be coupled with psychotherapeutic treatment. Anxiety-reducing

medications should be supported with emotion-focused therapeutic sessions: the anxiety can be reduced so that therapy is possible, and the therapy can help reduce the future need for medications. Cognitive-behavioral therapies can help reduce psychopathic symptoms, while healthy habits can help keep new symptoms from emerging.

Even more advanced medical treatment strategies, based on recent neurobiological discoveries hold great promise, if coupled with the healing presence of a "talking cure." (psychotherapy). For instance, neuro-feedback procedures can be effective in the treatment of trauma, but should always be set within a broader psychotherapeutic context—so that the trauma can be better understood by the patient so that future behavior and decisions are not driven by re-experiencing of the trauma or even re-victimization.

Patients who must live with voices in their head, as a manifestation of schizophrenia, may find relief in taking one of the newly available psychotropic medications that are less numbing of mental and emotional functions than medications prescribed in the past. However, these schizophrenic patients are likely to live much more pleasant and productive lives if they learn (through therapy) how to adapt to their occasional voices (perhaps even having a "productive" conversation with these voices).

All of this suggests that the fourth assumptive world is regarded with justification as the "best" of the four worlds I have identified. It is certainly the most "modern" and "scientific" of the worlds. I applaud the many advances made in the medical treatment of psychopathy. Yet, I am reminded of Frank, the VA patient who I met in the surgery ward. Strapped to the bed, having been tearing off the skin on his arms and legs, Frank had been the beneficiary for many years of "medical treatment." He had been hammered into a state of profound insanity by these healing "treatments." A World War II victim of what would much later be labeled "PTSD", I believe that he was being treated primarily for anger management when placed against his will in the hospital.

As a strong and unpredictably aggressive patient, Frank was no doubt a threatening presence on the VA ward; however, those providing "treatment" should not have been kidding themselves that they were trying to "cure" Frank – they were only trying to manage his behavior. Frank's files were filled with the jargon of medicine and contained no reference to issues of behavior management and control. Employee safety is a legitimate reason to provide restraint—yet this rationale was never mentioned in Frank's file. Our third assumptive world (social deviance) was alive and well (or not so "well") in Frank's hospital history—but it was never acknowledged. It was Frank's file and his status as a patient strapped down to a bed that radicalized me. I think assumptions should be made explicit. If they remain unacknowledged, then they can do great damage, regardless of their initial benevolent intent.

I would go one step further. The hiding of an assumptive world and its unacknowledged beliefs and destructive practices is often motivated by money. Financial considerations have a way of distorting the management of both power and anxiety. I turn now to this matter of money.

The Financing of "Mental Illness" Treatment

The interplay between medicine and money has always been very important in determining the level of influence and the directions taken by the medical industry (and related industries such as pharmacology and medical technology). In the United States, for instance, medical doctors during the 19th and early 20th Century were paid directly by their patients. They strongly opposed the intrusion of any third party into the trusting and in many ways "intimate" relationship that existed between themselves and their patients. These men (very few female physicians) certainly did not some non-physician determining who and how much should be paid for specific medical procedures.

All of this began to change in the early 1920s. There were now fewer physicians (many of them being thrown out of the profession by acts passed by the United States Congress during the 1910s). With fewer physicians to serve the public, the price of health care began to increase, and many patients could no longer afford these services. With some third-party payment plan in place (health insurance), the physicians could still charge a high fee while serving an expanding population of patients.

The health insurance business soon benefited from the introduction of benefit plans in American corporations. Employees now were being paid not only as wage-earners, but also as recipients of health and retirement plans. The United States government soon got involved too, passing legislation during the 1930s that provided some financial support for citizens who could not afford health insurance, were not covered by their employer, or were too old, too young or too infirmed to be eligible for any existing financial assistance. The stage was set for health care policies and procedures to be strongly influenced by the allocation of money (Bergquist, Guest and Rooney, 2004)

A similar story can be told about health care elsewhere in the world—though in most cases the primary financial player has been government. We see evidence of this today in the almost universal adoption of national health insurance or government controlled or even operated health care facilities. We find that physicians no longer run the show in most countries. As I noted in the first essay, social constructions are often reflected in the language (semantics) being used: in health care around the world we find financially related terms driving medical decision-making by both the providers and recipients.

Terms such as "cost centers" (medical services being delivered to patients) and "reimbursables" (medical services being initially paid for by patients but later paid for by a third party) are filling the offices and

corridors of medical centers and hospitals. Related marketing-based perspectives are also prevalent. Patient satisfaction surveys have replaced rating of medical success—for the patient has to be satisfied if they are to be continuing "income-centers" (either directly or through third party payers.

What then do we do about patients who are categorized as "mentally ill"? Can their treatment be reimbursed by a health insurance company or government agency? Initially, the answer was "no" in most countries. Only "legitimate" illnesses are eligible for compensation: the ghosts of the first three assumptive worlds lingered in the halls of government and corporations: "we don't help people out who are either crazy or can't handle their own emotional problems!" But what happens when you move from a social deviance or spiritual aberration world to a world in which these poor men, women (and children) have been afflicted with a "mental disease" or are born with a "mental deformity."? Aren't they just as much victims as a man struggling with diabetes, a woman suffering from cancer, or a child afflicted with polio?

We see here one of the most important reasons why the fourth assumptive world has won the day in most societies. There is money to be made in defining psychopathology as an "illness." Psychiatrists, psychologists and even primary care providers are willing to live with the strictures of DSM and the heavy use of psychopharmacological treatment plans if their services are being full compensated. I would suggest that there is something even more powerful operating: when money is involved there is a strong tendency to try restriction of trade.

Much as American physicians in the early 20th Century were able to significantly increase their own income by reducing the number of men and women (especially woman) providing medical services, so it is now tempting to restrict the number of "mental health" providers who can receive third party compensation for their services. We find the extensive use of "panels" in North American mental health plans: only certain mental health providers are eligible to be reimbursed for their services. In other countries, the government agencies providing compensation or direct services sets up strict standards regarding who can and cannot be compensated or even provide services.

The restrictions imposed in early 20th Century America resulted in the homogenization of American medicine—through the death of most nontraditional (homeopathic) medical training centers and the termination of most nontraditional medical practices. Medical schools that admitted women or racial minorities were also put out of business. As a result, American medicine was provided exclusively by white men who were trained in traditional, allopathic medicine. Only a scattering of nontraditional medical practices (such as chiropractic) were allowed to remain in business.

The same homogenization is now occurring in the treatment of psychopathology. DSM reigns supreme: a we will not in greater detail in our fifth essay, mental health providers must frame their description and diagnosis of psychopathy in DSM categories if they want to be reimbursed or (in some countries) want to stay in business. Similar, there are strict limits set on the number of psychotherapeutic sessions that can be reimbursed.

This leads to the almost exclusive use of brief therapy strategies (such as cognitive-behavioral therapy: CBT) and reliance of many psychiatrists on the exclusive use of (prescribing of) psychopharmacological agents. At best, the two strategies are combined with the psychotherapist using CBT and psychiatrist using a specific medication.

This money-driven homogenization also is built on a credential restriction: mental health practitioners must be graduates of fully accredited programs (that primarily offer traditional, fourth assumptive world perspectives on psychopathy). The "outliers" and advocates of new paradigmatic perspectives might be able to practice their "witchcraft" (after all we are an "open-minded" mental health community): but they certainly should not be reimbursed by any reputable organization for this "craft." As noted in a publication of the American Psychological Association, the world of mental health has moved from "seance to science." Our understanding of mental health issues has progressed with the application of solid scientific findings. We are now governed by "evidence-based" mental health perspectives.

All of this homogenization leads to one simple conclusion: there is no need at any time in the near future for a radical revision in our perspectives. We don't need to "rock the boat." Our existing assumptive world four paradigm shall remain intact for many years to come. We may be doing some minor modifications from time to time (probably every decade) in DSM and will be demanding that old versions of this manual be destroyed since we are now closer to the truth. All is well in the world of mental health illness. Or is this true? Are we really any closer to the truth about psychopathy? How do we deal with the trouble-makers – someone like Thomas Szasz who many years ago began criticizing the prevailing paradigm?

Thomas Szasz and the Myth of Mental Illness

The critique offered by Thomas Szasz is not new. It can be traced back to his most influential book: The Myth of Mental Illness that was published in 1974. Yet, his observations and critical appraisal of the fourth assumptive world still seems to ring true. In seeking to give Szasz's critique a fair hearing, I will offer both a "Weak Szasz Hypothesis" and a "Strong Szasz Hypothesis" (in keeping with the Weak and Strong Whorfian hypothesis I offered in the first essay). I will first offer the weak version – which most contemporary observers of mental health operations around the world can probably accept.

The Weak Szasz Hypothesis

This critique is directly in line with the social constructivist perspective I offered in the first essay: mental illness is a social construction and not an absolute "reality" At the very beginning of *The Myth of Mental Illness*, Szasz offers a quotation from Karl Popper (a noted philosopher and historian of science): "Science must begin with myths and with the criticism of myths." In making this statement, Popper (and Szasz) are aligned with Thomas Kuhn and his structure of scientific revolution.

Though Popper and Kuhn differ in many important regards in their narrative about science, they seem to agree that science is not simply (or even complexly) and compilation of proven, verifiable truths. There is a whole lot of speculation, bias and self-fulfilling prophecies lingering around the halls of science – and especially around the halls of those behavioral science practitioners who like to think of themselves as being rational, systematic and open, as Popper suggest, "to the criticism of [prevailing] myths [and paradigms]."

For Szasz, the concept of social construction goes well beyond the usual "tame" version that social constructions are somehow arbitrary and often are founded on some random events or discoveries—such as Marie Curie's discovery of penicillin or Salk's discovery of a cure for polio. Szasz believes that mental illness was not some disease that had just been discovered or that the treatments employed in the treatment of specific mental illnesses were somehow arbitrarily discovered (such as Freud's invention of the "talking cure" because he was a lousy hypnotist).

Rather, mental illness was an "invention" (Szasz, 1974, p. 12): "whereas in modern medicine new diseases were discovered, in modern psychiatry they are invented (e.g. hysteria)." Thus, Freud might have "discovered" the talking cure—but he was deployed this treatment strategy in addressing a form of psychopathy that had been re-invented over many centuries. What is it like to treat an invention: are the therapist and patient sharing a delusion? We are hovering on the edge of a Strong Szasz Hypothesis.

The Technologies of Mental Illness: As I noted in the first essays, the models being used in many disciplines are often borrowed from "fashionable" technologies that are associated with and frequently generated out of prevailing paradigms in another discipline. In the case of psychiatry and psychology, these technologies have been about medical diagnoses and drug prescription. These technologies, in turn, come out of the analytic tradition to be found in both classical physics and chemistry, and the biochemical tradition to be found in both biology and chemistry.

Szasz seems to be alluding to this borrowing when he (Szasz, 1974, p. 4) indicates that: "so-called psychiatric problems continue to be cast in the traditional framework of medicine The conceptual

scaffolding of medicine, however, rests on the principles of physics and chemistry Yet the fact remains that human sign-using behavior [mental and unsubstantial rather than physical and tangible] does not lend itself to exploration and understanding in these terms." I proposed that Szasz has hit on two important underlying paradigms in his "dissection" of the fourth assumption world: (1) analysis and (2) causality.

Paradigm One: Analysis. Szasz (1974, p. 11) points to the analytic tradition of biology (what I described in the first essay as the "smashed frog" perspective) with regard to the dissection not only of frogs, but also human cadavers: "After dissection of the body was permitted, anatomy became the basis of medical science." With the insights about human anatomy that were revealed through careful dissection, it was only "natural" that similar principles be applied to the dissection of mental "illness." It was assumed that we can learn much from laying out the mental illness on the laboratory table and determining each of its working parts—and identifying, in particular, the "diseased" entity in the human psyche that accounts for the aberrant behavior and feelings to be found in the mentally ill patient.

Paradigm Two: Causality. With the dissection of mental illness comes the identification of causality. Borrowing from the traditional physical sciences, we can envision a world filled with billiard balls. One ball hist a second ball and the second ball is forced to move. This is the fundamental principle of causality and is clearly aligned with the right-branching (active voice) syntactic structure identified in the first essay. This billiard ball universe is now being seriously questions in the physical sciences, as it becomes clear that most physical systems in the real world are highly complex and operate in a manner that defies the standard billiard ball perspective and any hope of predictability: there are multiple causations, operating alongside self-organization and (as I noted previously) the emergence of new, unanticipated forms.

Put in a somewhat different context, the billiard ball perspectives is clearly inappropriate when applied in such "messy" and perhaps pre-paradigmatic disciplines as history, psychology (and the other behavioral sciences). We tend, for instance, to offer historical narratives that move from past to present, identifying how specific events in the past have "caused" our current condition. The analysis paradigm (focusing on special events) joins with the causality paradigm (looking for simple direct line connections) to create what is often called "historicism." Yet, this not the way in which history is actually generated: we are always looking from the present time back to the past and are trying to figure out from our current perspective "how we got to where we are." Past "causative" events of the past are always viewed (in a very biased way) from the present.

This same "*historicism"* seems to pervade the assessment of mental illness. Pointing to the perspectives of "historicism", Szasz (1974, p 5) notes that it has traditionally been assumed that: "historical events are

as fully their antecedents as are physical events by theirs." Billiard balls hit billiard balls. Childhood trauma causes adult mental illness. Genetic defects cause schizophrenia and bi-polar disorders. Under the shadow of psychological and psychiatric historicism, we are left with a world in which there is no free will. External locus of control is the coin of the realm in this fourth assumption world. We return to Szasz (1974, p 13): "diseases happen to people Mentally sick persons did not "will' their pathological behavior and were therefore considered "not responsible."

At this point, the legal system comes into compliance with the dominant fourth assumptive world: there are legitimate defenses made for the declaration of "innocence" on the basis of mental illness. When we get to this point in our analysis of the fourth assumptive world, the fatal flaw (or least point of deep concern) emerges. The Weak Szasz Hypothesis would suggest that we are left with the absence of any personal accountability or any fundamental moral code if the fourth assumptive world remains dominant. According to Szasz (1974, p 263): "human behavior is fundamentally moral behavior Attempts to describe and alter such behavior without, at the same time, coming to grips with the issue of ethical values are therefore doomed to failure"

The Strong Szasz Hypothesis

As we move to Szasz's challenge regarding the loss of morality in the fourth assumptive world, we begin our venture into what I would call Szasz's "Strong Hypothesis." This is where Szasz becomes quite controversial and where many members of the mental health community steer clear of Szasz and his arguments. Yet, much of what Szasz offered more than 40 years ago is disturbingly contemporary.

First, we need to recognize that Szasz is not just suggesting that mental illness is a social construction. He is suggesting (in according the third assumptive world) that mental illness is an invention that was creating and is employed to suppress individuality and maintain oppressive social institutions and practices. He believes that it is not just money and mental health that are in alignment—it is also power and mental health that seem to be interwoven—and perhaps are now inextricable in many countries.

As I have repeatedly asked in this series of essays: Who is at the table when psychopathy is being discussed. Has the "God" of medicine replaces the "God" of theology and the "God" of government and societal norms. Has even a combination and coalition of several Gods (spiritual aberration and social deviance) been unequal to the task of buffering the influence of the God of medicine. (Szasz, 1974, p 7) Szasz (1974, p. 260) makes it clear as to who he thinks is in charge: "The psychiatrist [is the] social

engineer or controller of social deviance. In this role, the psychiatrist acts as priest and policeman, arbitrator and judge, parent and warden: he coerces and manipulates, punishes and rewards, and otherwise influences and compels people, often by relying on the policy power of the state “

Concluding Comments

This fourth assumptive world is very powerful. Furthermore, I would suggest it has yielded both great benefits and significant harm. We must be attentive, therefore, to what Thomas Szasz has proposed – in both his weak and strong version. It is important to note that Szasz himself had been a physician and still placed “M.D.” beside his name on the title pages of his books. He is issuing a strong statement and is still regarded as a troublemaker and paradigm challenger who dwelled in in an assumptive world of the 1970s that was dominated by the medical model. This assumptive world still seems to be dominant – perhaps even more dominant in many societies that previously was in the throes of the second (or even first) assumptive world.

Furthermore, it seems to be world that can still offer not only cures, but also destructive classifications and resultant miscalculations regarding prognosis and treatment. Szasz has offered us a compelling description of the crippling impact which the social construction of “illness” can have on individual people and a society. I close this essay with a final quote from Szasz (1974, p 262): “The notion of a person ‘having a mental illness’ is scientifically crippling. It provides professional assent to a popular rationalization—namely that problems in living experienced and expressed in terms of so-called psychiatric symptoms are basically similar to bodily diseases. For a society, it precludes regarding individuals as responsible persons and invites, instead, treating them as irresponsible patients.”

References

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