

COLLEGE COUNSELLING IN THE AGE OF BIOLOGICAL PSYCHIATRY

A SZASZIAN PERSPECTIVE



John Breeding undertakes a critical examination of psychiatric narratives of mental illness, and considers the work of Thomas Szasz as a corrective lens through which to view student distress



Leaving home and coming of age have always been challenging. University counsellors know from personal experience some of the challenges of higher education, and are trained in the psychology of emerging adult development, and in various counselling methods to help college students with manifestations of psychological distress. In the last three decades, however, there have been developments that intensely complicate the job. These include things that directly impinge on college students, such as the rise and ubiquitous presence of electronic communications technology, global economic forces affecting the process of finding work, and the incredible costs of higher education and the resulting crisis of mountainous debt that graduates carry as they matriculate. But there is another crisis, specific to the field to which we mental health professionals belong. The current state of mental health practices, and the theories and assumptions that underlie and justify them, impinge deeply on every professional counsellor. In this article, I briefly summarise the trend, and offer another perspective, featuring the work of Thomas Szasz.

Situation analysis

There are two related trends in the mental health field I wish to emphasise. First, the normalisation of the concept of mental illness, and the growing number of people considered to suffer from some form of it. Second, their 'treatment' with psychiatric drugs. Both trends are pervasive throughout Western society. Between 1970 and 2000, there was a 40-fold increase (from 175,000 to 7,000,000) in school age children on stimulant drugs in the US, mostly for so-called attention deficit hyperactivity disorder

(ADHD).¹ In another example, researchers found a similar 40-fold increase in the number of 'bipolar' youth between 1994 and 2003.¹ A large percentage of these young people are administered antipsychotic drugs.² A large number of US students enter college already on psychiatric drugs, or start taking them while in college.

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By 2003, 40 per cent of those seeking help were already taking one or more psychotropic drugs. In 2005, they were often prescribing for themselves and each other.³ In colleges, ADHD, depression and anxiety disorder are among the most frequent diagnoses. The push for universal mental health screening has been relentless. In the UK, a recent article by Jo Smith, Professor in Early Intervention and Psychosis at the University of Worcester, cites a survey claiming that 78 per cent of university students reported mental health problems in the last year.⁴ She advocates suicide prevention programmes and cross-service work, culminating in a university mental health day.

The rhetoric sounds great, but it is important to take a close look at what is happening and at the actual effects of suicide prevention and mental health screening programmes. Screening programmes tend to have very high rates of false positives, and organisations supporting these initiatives are very often funded by the pharmaceutical industry.⁵ Why would pharmaceutical companies want to support such an organisation? Are they altruistic, or do they simply stand to make billions on the sale of drugs to the people who will be screened?

Biological psychiatry

There is one model that undergirds the mental health system, and that is biopsychiatry. This assumes that problems in living, or perceived failures in social adjustment, are due to biological and/or genetic defects. Social and psychological distress, and challenges in personal growth and transformation, are reduced to the chemical imbalance theory and the bad gene theory. These beliefs justify the practical mainstays of psychiatric practice, mostly drugs and electroshock treatment.^{6,7}

There are conflicting opinions about the value and validity of biopsychiatric theories, but it is vital for counselling professionals to recognise that they are no more than theories, and to resist ongoing false presentations by the media, drug companies and psychiatric profession as if the theories were facts. Incredibly, there is a complete lack of scientific proof for both the bad gene⁸ and chemical imbalance postulates,^{9,10} and an absence of any objective test or indicator of 'mental illness'. Whitaker's *Anatomy of an Epidemic*¹¹ clearly articulates problems with the chemical imbalance theory, and is the most thorough and up-to-date review on the dangers and ineffectiveness of various classes of psychiatric drugs. Whitaker makes a strong case that psychiatric drug treatment is a significant contributor to the spiralling number of our citizens who fail to achieve independence, who become chronic mental patients instead, considered permanently disabled for life.

A primer on Thomas Szasz

Thomas Szasz, a Hungarian-born American psychiatrist, died on 8 September 2012, aged 92. His work is fundamental to understanding our place as counsellors in the mental health system.¹² With the publication of *The Myth of Mental Illness*,¹³ Szasz launched a long career as the leading intellectual critic of his own profession and played a major role in educating many professionals of my generation. Yet I have spoken with many counsellors who know hardly anything about the man, and have read none of his books. I provide here a select few of his ideas relevant to this article, but I strongly urge any reader who has not spent time with the writings of Thomas Szasz to do so.

The concept of mental illness

Szasz taught that language is power, and that confusion and lack of clarity about language may bode disaster. His first requirement for seeing the truth and being effective was to be clear about language. He also pointed out a huge pitfall:



'Although linguistic clarification is valuable for individuals who want to think clearly, it is not useful for people whose social institutions rest on the unexamined, literal use of language.'¹⁴ His first big idea is that 'mental illness' is a metaphor. To assume it as fact is a dangerous error.

Scientific medicine distinguishes between a sign and a symptom. Symptoms are mostly subjective indicators of distress or discomfort, whereas a sign is an objective physical or chemical abnormality that has been scientifically validated in the literature as an indicator of a specific disease (eg elevated white blood cell count is evidence of infection). Astounding as it may seem, no problem routinely seen by psychiatrists has been scientifically demonstrated

to be of biological or genetic origin. Not one diagnosis of 'mental illness' is made by an objective finding of physical or chemical abnormality.

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Psychiatric diagnoses are based on troubled or troubling behaviour, and one cannot diagnose disease from behaviour. Mental illness is a metaphor, and literalising the metaphor has serious consequences. The assumption of biologically based mental illness as causative of psychological distress or troubling behaviour is the justification for using psychotropic drugs, and calling them medicine. Psychiatric diagnoses do not generally provide us with much that helps to understand our clients more deeply and clearly.

Rather, such diagnoses are prescriptive, indicating a recommended course of action. Troubling mood or behaviour, interpersonal or institutional conflict leads to diagnosis, and diagnosis leads to treatment. Within the framework of biopsychiatry, that treatment is usually drugs, and even if we as professional counsellors do not prescribe the drugs, we are left to deal with their effects, which are vast. As Thomas Szasz comments: 'The point is not that psychiatric diagnoses are meaningless, but that they may be, and often are, swung as semantic blackjacks: cracking the subject's respectability and dignity destroys him just as effectively, and often more so, as cracking his skull. The difference is that the man who wields a blackjack is recognised by everyone as a public menace, but one who wields a psychiatric diagnosis is not.'¹⁵

Liberty and coercion

Szasz's life mission was to challenge coercion in his chosen profession.¹² He hated psychiatric coercion and constantly challenged its twin pillars of involuntary commitment and the insanity defence. It may be that many university counsellors feel they manage to steer mostly clear of coercion, but it is really impossible to avoid when you work within inherently coercive systems.¹⁶ It is important for every counsellor to think deeply about our place in this dynamic. Where there is coercion, even in its subtle forms, our role is less that of counsellor and more of jailer or enforcer of 'normalcy', social adjustment or the status quo.

Privacy

Thomas Szasz placed great value on privacy. In *The Therapeutic State*,¹⁷ he clearly detailed the obvious, systematic privacy violations inherent in coercion. Any time a third party payer is involved, privacy is compromised. Privacy is an intense challenge for the thoughtful counsellor in today's world where the question of whether privacy is even possible in the modern high tech surveillance state, specifically with any form of electronic medical record, is all too real. For Szasz, the solution was simple. He only worked privately, under contract with his clients, and privacy was sacrosanct. Given that our counselling ethical frameworks, or contracts of employment, suggest that confidentiality violations are required in certain circumstances, very few counsellors align with him on this. It behoves us all to examine closely our ethical stance regarding our confidentiality contracts with clients.

Autonomy and responsibility

The field of counselling provides important services to those in distress. There is a wide range of counselling theory, and exciting developments in areas such as trauma counselling and relational approaches. Summaries of psychotherapy outcome data suggest that specific theory and method are not nearly so important as the quality of the relationship between client and counsellor. The biggest factors, though, at least according to the work of Duncan and Miller¹⁸, are 'extratherapeutic', meaning they operate independently of the counselling relationship. In their research, 40 per cent of improvement during counselling is due to client factors such as persistence and openness or a supportive

grandfather, or getting a new job. As the authors put it, 'neither guru therapists nor their carefully acquired silver bullets are the defining factors of change'.¹⁸ This is an important reminder to all of us,

and it is also directly relevant to what follows.

Many people do not realise that Szasz was actually a practising counsellor for most of his professional life; he called it 'talking and listening'. I think he knew that the counsellor was a relatively minor player in a person's life, and that even if this were not true, he still would have insisted that such an attitude was the only respectful and truly helpful way to go. He said it like this: 'The result of

psychotherapy can only be that the subject is, or is not, persuaded to feel, think, or act differently than has been his habit. The client changes some of his ways or he remains the same. The psychotherapist does not do anything but listen and talk. If there is any change in the client, it is, in the last analysis, brought about by the client himself.'¹⁹

It is obvious when the law overrides citizen autonomy and responsibility in the name of mental illness. Subtler aspects of paternalism can be more difficult to see. Every counsellor should think deeply about the role of labelling, and especially of psychiatric drugs in undermining autonomy. Peter Breggin²⁰ lays out the clearest case I know of the wide-ranging effects of involuntary intoxication caused by psychiatric drugs. A common thread is that drugs disable self-awareness to varying degrees, thus inevitably undermining autonomy and responsibility. I wrote a recent commentary on the incredible challenges a counsellor faces when working with young people labelled mentally ill and placed on psychiatric drugs.²¹ Once an individual is labelled with a biologically based 'mental illness', his school, his family, his community, and society are all magically absolved from the need and responsibility to keep thinking, to examine themselves, to question the nature of the community, to look at oppression at any level in the society. Instead, everyone can act as if the situation were explained by bad genes or biology causing mental illness in the poor soul who is the identified patient. In addition to problems related to autonomy and responsibility, there is also the conflation of drug effects and human dynamics, drug withdrawal, and suppression of emotional expression, among others.

Conclusion

I have written elsewhere^{21,22} about my experience of practising counselling with the teachings of Thomas Szasz in mind. I end here with just a few thoughts. When I started publicly challenging the psychiatric drugging of children over 20 years ago, a frequent question was 'What are your solutions then?' It is important to offer alternatives, but I strongly feel that resisting the default option of psychotropic drugs for our young people is a vital mission, and that helping any young person to avoid or lessen the allostatic load of these drugs is a solution in itself, especially in optimising the possibility of self-determination and maturity. There are massive structural and systemic problems impacting our counselling bubble, but at the very least we can resist the tendency to forsake our trust in counselling

support when the going gets tough, and too easily accept a biopsychiatric interpretation and the presence of drugs in our client's life. One effect of a psychiatric diagnosis, and of drugs, is to undermine the responsibility of everyone involved, as the 'mental illness' becomes the explanatory factor and treatment is the solution. When that happens, everyone tends to stop thinking. My request is that counsellors never stop thinking about the uniqueness of people and the multicausal influences on a young person's life – physical, emotional, mental, relational, and spiritual. When the going gets hard, we need to keep doing whatever it takes to bring ourselves back to that place of relaxed confidence that our clients, with our encouragement and support, can get through hard stuff, and intense states of mind. ●

ONE EFFECT OF A PSYCHIATRIC DIAGNOSIS, AND OF DRUGS, IS TO UNDERMINE RESPONSIBILITY OF EVERYONE INVOLVED, AS THE 'MENTAL ILLNESS' BECOMES THE EXPLANATORY FACTOR AND TREATMENT IS THE SOLUTION



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