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Medicine’s Frankenstein

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SET QUESTION

What is the distinction between mental illness and problems in living? Justify your answer.

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Awarded a merit.

In the introduction, of his The Myth of Mental Illness, Thomas Szasz makes three interesting observations that are relevant to the scope of this paper. First of which is that (1) psychologists and psychiatrists deal with issues that are moral in nature rather than medical. Therefore, by extension, there is no good reason why they require medical interventions. Secondly, strictly speaking, (2) there is no specific scope that limits the psychiatrist or the psychologist to a fixed job description. They engage in myriad of activities like examine patients, prescribe, sanction electric convulsions, sign off on commitment papers, testify, "and so forth almost ad infinitum". There is really no fixed scope that puts the psychiatric-psychological enterprise in a category. The cost of that (especially with an enterprise claiming to be medical) is a lack of ability to recognize when the enterprise oversteps its area of expertise. Lastly, the third observation made is the claim that (3) "mental illnesses" are invented rather than proved. Take for instance hysteria and paresis; in the case of paresis, it was proven to be a disease, but on the other hand, hysteria was merely declared to be one.

These three observations are integral to understand that "mental illness" and "problems in living" are the same phenomena. "Mental illnesses" are a modern creation that relabels problems in living, almost hijacked by the medical enterprise by attributing the phenomena to medicine for no real reason. I agree with Szasz insofar as "medical illness" and "problems in living" are describing the same phenomenon, they largely overlap but not completely; there exists a nuanced strand that renders both labels non-identical. Therefore, where I minorly disagree with Szasz is his blanket equivalence between the two concepts, however, they still do describe the same phenomenon.

In this paper, I shall argue that there is no distinction between "mental illness" and "problems in living"; they are both describing the same phenomenon. However, although there is no distinction between both labels, they are not identical as far as Leibniz's law of "indiscernibility of identicals" is concerned. I also argue for the superior accuracy and coherence of one label, namely "problems in living", over the other when referring about the phenomenon in question. Lastly, I show why "problems in living" happened to be part of medicine when really, a medical practitioner is no more qualified to solve said problem than a plumber or a carpenter. I expound on this in sections I and II.

I further attempt to offer a diagnostic solution that could allow for better clarity between both labels by exploring the psychoanalytic and medical enterprise. I expound on this in section III.

Section I

A. "Mental Illness" and "Problems in Living" Describe the Same Phenomena

Speaking of the non-difference between the two, the concept of “problems of living” was famously coined by Thomas Szasz who believed that mental illnesses were a modern creation that relabels problems of living (Neurosurgery, 1979). In his book, “The Myth of Mental Illness”, he says:

> Thus, whereas in modern medicine new diseases were discovered, in modern psychiatry, they were invented. Paresis was proved to be a disease; hysteria was declared to be one. (Szasz, 2011, p. 16)

It is a classic case of the fallacy of equivocation. There are a group of people who subscribe to the medical label of the phenomenon, and there are a group of people who subscribe to the Szaszian label of the phenomenon. Take for instance the two labels: “freedom fighters” and “terrorists”.

The former label is given to the fighters by those who support the cause of said fighters, whereas the latter label is given by those who are against the cause of said fighters. They are both describing armed conflict. Depending on the observer’s stance on the group that said fighters are in conflict with, a label will be chosen.

There are a group of people who believe that “problems in living” are pathological in nature and since medicine seeks to heal pathologies and alleviate suffering caused by said pathologies, then it is now a problem that requires medical intervention and from that understanding, these problems are no longer “problems in living”, they are “mental illnesses”.

The key point of contention is the type of “suffering” that medicine is genuinely equipped to alleviate. It is not obvious that medicine shall take it upon itself as an enterprise to attenuate any and all types of suffering merely because it is to do with the “human anatomy”.

B. The Scope of Medicine and the Type of Suffering It Seeks to Alleviate

If person Y is going through unimaginable magnitude of suffering due to injustice. To illustrate, suppose person Y hired a contractor and paid the contracting company a large sum of money for a certain type of work done within time t. The contracting company failed to complete the work within the specified timeframe t and demonstrated incompetence in the services they were hired to perform. Person Y not only lost money and time, but must also rectify all the improper work done. To alleviate this kind of suffering (injustice and loss), person Y ought to go to court where ideally, the money will be refunded along with an additional sum as compensation for the delay and the damage that the contracting company's incompetence cost. There are many types of suffering that a human being may experience, just like law is equipped to solve the specific type of suffering caused by injustice, the medical enterprise is equipped to alleviate a specific type of suffering. This takes the discussion to the next point of contention.

The type of suffering the medical enterprise is concerned with could be extrapolated from the back-and-forth attempts to define "diseases" and "health". Approaching the problem by defining "diseases" and "health" is almost mandated by medicine, since these are the terms it uses to define its own scope. However, both terms are value-laden, leaving them open to several interpretations. But in my view, there could be a simpler approach to determining the type of suffering medicine attempts to alleviate observing the categories of suffering that a human may experience. Inspired by the "mind-body dualism" classification (Robinson and Weir, 2026), as a human with the aforementioned classification build up, suffering could be of two types: (1) mind and (2) body. Where the mind is defined completely by thought and consciousness, whereas body is extended in space and physical.

If person X was slapped across the face, then bodily, (1) said person's cheek would physically (or biologically) pain. As far as the mind is concerned, (2) said person may feel humiliated and ostracized, said person may also experience great injustice. Based on these classifications of suffering, it is quite straightforward which category of suffering that medicine ought to be alleviating. Person X may be experiencing shame, anxiety and panic whenever they remember (or see) the aggressor. Person X may also stop experiencing

all those negative thoughts when the aggressor gets punished in a befitting way, and when the effect of justice is observed. Person X may also stop experiencing all those negative thoughts if they slap back their aggressor.

Regardless of how the problem is solved, it should most-certainly involve a “mind” solution because it is a problem in the category of the “mind”. Using a “body” solution (medicine), would be a category error; it would be similar to using a screwdriver to troubleshoot a problem in a computer code.

C. "Problems in Living" as a More Coherent Label Than "Mental Illness"

The coherence of “problems in living” over “mental illness” as a label to the phenomenon in question is evident from Alzheimer’s. “Mental illness” may sometimes function as a placeholder for genuine neurobiological illnesses that technology cannot yet declare as a physical illness. Alzheimer’s is known today to be a neurobiological disease (Lui and Tsao, 2026). However, Jesse D. Ballenger in his discussion in dementia’s historical development says:

> From mid-1930s through the 1950s, a number of American psychiatrists led by David Rothschild responded to the challenge of dementia in the state hospitals by framing dementia as a psychosocial problem rather than a brain disease. (Ballenger, 2017) This shows to say that mental illnesses can sometimes contain genuine physical (i.e. of the body) diseases but misattribute said actual illnesses to problems in living. Therefore, the mental illness label conflates both body and mind categories. It is often used as a placeholder for neurobiological diseases that the medical enterprise cannot technologically detect at said given time. Just like with Alzheimer’s; at a certain time, there were no scans, no tools that could clearly detect physical abnormality. Therefore, instead of comfortably showing that the brain is damaged, the contemporary accounts of Alzheimer's (or dementia) from the mid-1930’s through the 1950’s overwhelmingly produced psychoanalytic explanations of the condition. The

psychoanalytic enterprise was filling the gap in the technological ability of medicine. The phenomenon, let it be called “Phenomenon X” in question (that both labels attempt to name) assumes problems that (1) cannot be empirically verifiable, (2) does not include tissue damage, (3) value laden (or non-objective), (4) are defined as a deviation from social norms.

> Problems in living as a label is a more befitting name to this condition. Mental illness as earlier shown could not only include Phenomenon X but also, genuine neurobiological diseases that medicine cannot empirically capture yet. Mental illnesses is in an awkward permeable position between actual medical issues and ethical and social issues. In a way, the psychoanalytic enterprise is (1) a category error insofar as it tries to medically solve a problem that is inherently non-medical, and (2) is used as a preliminary step before a disease qualifies as a neurobiological disease. Alzheimer's (or dementia) is not the only instance of that; it is just one of many. Stefan Schleim, whose work has fundamentally challenged the neurobiological turn in psychiatry, argues that:

> ..though it should also be mentioned that diseases like epilepsy or Parkinson's which were originally understood as psychiatric disorders moved to neurology after the discovery of strong neural markers (Schleim, 2022)

The psychoanalytic enterprise would hold diseases like epilepsy, Parkinson's, Alzheimer's (or dementia) and far more. Those diseases would not yet have medical empirical validity but are actually and inherently medical problems. Which would mean that the

psychoanalytic enterprise is momentarily responsible for treating diseases that are associated with neurology, therefore the symptoms the patients would be exhibiting are rooted from a neurological condition (physical condition that is of the "body"). So, it looks as if the enterprise is concerned with genuine medical problems (which they are, but temporarily until the case gets transferred to neurology). This adds to the confusion and gives the psychoanalytic enterprise a false façade of medical authority. The problem occurs when undetected neurobiological diseases are under the psychoanalytic enterprise along with "problems in living" or Phenomenon X. The "treatment" for undetectable neurobiological diseases could certainly be solved using interventions that are of the "body".

However, what if the enterprise, not only, expands its scope to solve problems that are also of the "mind", but also, uses the same intervention to "treat" both and cannot even differentiate between them?

By this reasoning, I hope to have shown that there is a label that is more coherent and accurate than the other, namely, "problems in living". The

“mental illness” label gives the illusion that the phenomenon in question is medical, however, there is no reason why it must be categorized as a medical problem. In a way, the grand confusion occurs when the medical enterprise aims to formalize and offer solutions to Phenomenon X. The reason why the medical enterprise confuses “problems in living” as part of its scope is due to cases like Alzheimer’s etc. that were initially misattributed to “problems in living” (due to ignorance) and was later discovered to be neurobiological.

It could be falsely assuming a medical classification to conditions such as depression, anxiety, panic and so on (insofar as these conditions are purely of the “mind”); when there is no philosophical reason why these “problems in living” require medical intervention. Expanding on Thomas Szasz in his book, “The Myth of Mental Illness”, he explains that there is no clear defining pursuit that psychiatry commits to, and proceeds to list several activities psychiatrics engage in as part of the “job” and ends it with: “ad infinitum” (Szasz, 2011, p. 6).

Section II

A. “Mental Illness” and “Problems in Living” Are Non-Identical

Speaking of the non-identicality between the two, Leibniz’s law of “indiscernibility of identicals” requisites that if X and Y are exactly identical, then every property of X belongs to Y and vice versa. Say for instance, if Kitab (the Arabic word for “book”) and Hon (the Japanese word for “book”) are both books, then every property of a book belongs to both Kitab and Hon. I argue that this is not the case with “mental illness” and “problems in living” since there exist cases that are attributable to a “mental illness” but not attributable to “problems in living”; namely, schizophrenia (as well as Alzheimer’s, epilepsy, Parkinson’s and so on as earlier discussed).

Although schizophrenia is a “mental illness”, it does not qualify as a “problem in living”, it becomes a disease that is neurobiological from the Szaszian perspective. There is certainly a case to be made for the condition to be classified as medical. For instance, The American Psychiatric Association (APA) defines schizophrenia as a “chronic brain disorder” (What is Schizophrenia?). Also, the National Institute of Mental Health (NIMH) affirms that causes involve “different genes”, environment and brain size

(Schizophrenia - National Institute of Mental Health (NIMH)); medicine might have not clearly zeroed in on a single cause, but it is clearly neurobiological.

Inability to physically diagnose does not necessarily mean that the illness is not physical; for instance, in the absence of modern medical measurement devices (as was the case in the past) such as the “glucometer”, there existed no physical method of diagnosis to identify that a person with an irregular blood sugar level is a “diabetic”. By the same token, just because modern medicine is unable to physically diagnose schizophrenia, it does not render the condition non-physical. This is especially relevant considering that modern medicine picks up on multiple physical queues (i.e. neural markers) pertaining to the condition, it is just unable to physically diagnose it.

It is again relevant here, the case study of Alzheimer’s disease in its historical trajectory; it was initially classified within psychiatry (as a “mental illness”) given the overwhelming psychoanalytic theodicies of the condition. However, modern medicine strictly classifies it as a neurobiological condition. The relevance of this to the ultimate point I hope to establish is that schizophrenia in particular may be in the primitive stages in its historical trajectory and that enough is already known for it to be outside of the “mental illness” classification and revised to be a neurobiological condition. In other words, schizophrenia now could be what Alzheimer’s was to the psychiatric enterprise in the 1930’s through the 1950’s. The differences between “mental illness” and “problems in living” are confused specifically because of the psychiatric-psychological conflation of both “mind” and “body” problems.

Section III

A. Diagnostic Solution: Deeper Look at Psychoanalytic Enterprise

A solution could be achieved if the psychoanalytic enterprise could be objectively classified. An objective approach is to define it through a dualist framework. Does the enterprise treat the “body” or the “mind”? The answer can be both as long as there is an acknowledgement of that. It would be problematic insofar as it lacks specialization and efficiency. It would also comically enlarge the scope of the enterprise as it would be a massive

project that just one enterprise could not possibly be able to cover the needs of. However, it is a plausible answer as a starting point. There are three routes that could be taken in the event that a dualist framework is employed to define the scope of the psychoanalytic enterprise.

In the case that the condition that requires treatment is of the (i) "body", then using an intervention of the same classification is warranted and needed (i.e. medications, surgery etc.) and in practice, that is precisely what the medical enterprise practices which would mean that it is part of medicine.

Here, it could very well be preliminary discipline that could be concerned with diseases that could potentially be of the "body". The psychoanalytic enterprise could be responsible for (i) finding if the disease at hand has any physical markers that could qualify it to be within the scope of medicine, and (ii) classify it according to the befitting discipline. It could work as the R&D committee of medicine to decide whether or not a "disease" should be treated medically and if yes, what discipline should be responsible of said "disease". Take for instance, a patient with a panic attack, the psychoanalytic enterprise would first investigate whether the condition has a somatic basis, such as vagal nerve dysregulation, which is increasingly understood to be a physiological driver of both panic attacks and IBS (Breit et al., 2018). If a somatic marker is observed, the psychoanalytic enterprise would refer the case to the appropriate branch which in this case would be gastroenterology. If there are no somatic markers observed, then the psychoanalytic enterprise could keep searching for physical markers and declare the condition to be under revision; or the case could be declared as fully non-physical to which it would be outside the scope of medicine. Another example is schizophrenia, as earlier shown, there are neurological and physical markers for the condition (at least, there is enough to qualify it as a "bodily" condition); here, the psychoanalytic enterprise could firstly qualify it as a medical condition. Then, it could further investigate the condition further to pinpoint the exact root cause. Assuming it is neurological, the psychoanalytic enterprise then hands it over to the specialized group and that is where their scope ends.

In the event that the psychoanalytic enterprise acknowledges that it attempts to treat (ii) both the "mind" and the "body" (as is true to reality) as earlier shown, then there ought to be a method of diagnosing whether the condition is of the "body" or of the "mind". In the case that the condition that requires "treatment" is of the (iii) "mind", then an intervention of the same

category ought to be enforced (i.e. non-medication approach and solutions that are of the “mind”). Logically speaking, in both cases (ii) and (iii), the psychoanalytic enterprise needs to justify why it is qualified to treat problems of the “mind” since its efficacy is not obvious.

To begin with, the psychoanalytic enterprise has publication and reporting biases that inflate efficacy. There is good reason to be cautious of published evidence. Not only is there a case to be made for the enterprise’s lack of scientific rigor, but having to be wary of its published evidence is the nail in the coffin. It is studied and almost settled that unfavorable treatment outcomes are unlikely to be published. This shows to tell, that even published evidence goes through a value-laden selective system to which the criteria of, are unknown to the public. There are scant foundational reasons why the psychoanalytic enterprise can be trusted to treat the “mind” let alone be named as a science at all. (Hengartner, 2018)

Not only that but, whether psychotherapy rests on solid science or pseudoscience remains an open and contested debate. One of the defining features of solid science is replicability. Another crisis that the psychoanalytic enterprise struggles with is its ability to replicate studies. OSC (Open Science Collaboration) ran an independent study to cross reference originally published studies. Original studies reported 97% yield of significant results. The independent rerun studies reported only 36% of significant results. This also bleeds to the previous point of contention: Could the enterprise in good-faith be called an “evidencebased” science (i.e. scientific)? (Open Science Collaboration, 2015) In short, a diagnostic solution to the confusion between labels could be achieved if the scope of the psychoanalytic enterprise is objectively defined through a dualist framework. This allows for three objectives to what the enterprise attempts to achieve: either (i) alleviation of the “bodily” aggrieved or, (ii) alleviation of both the “bodily” and “mindly” aggrieved (iii) alleviation of the “mindly” aggrieved.

In the case that it is (i), then it could plausibly be a subdiscipline of medicine that preliminarily treats and researches diseases that only have neural markers (i.e. immediately eliminate any “disease” that have no physical queues) until the disease gets distributed to the rightful discipline (likely to be neurology); it could be the R&D (research and development) subdiscipline of neurology. Simply put, it would be responsible to (1) identify if the “disease” is physical and if it is, it will (2) distribute the disease to the rightful

specialized body of medicine (be it neurology, gastroenterology etc.)

In the case that it is (ii) or (iii), then the psychoanalytic enterprise ought to produce enough evidence to qualify as an evidence-based science that is well-qualified and equipped to tackle the “diseases” of the mind. It ought to also be able to be replicable as this is one of the essential features of solid science. Lastly, it must feature an intervention that does not commit a category mistake. If the enterprise concedes that it only treats the “mind”, then it cannot use a “bodily” intervention as earlier discussed. Just like it would be absurd to treat a patient suffering from a “bodily” disease using a “mindly” intervention such as speech or enforcing the law.

In this essay I have argued that both "problems in living" and "mental illnesses" are labels for Phenomenon X, and in practice, they are interchangeable. To subscribe to "problems in living" is to find the Szaszian account of Phenomenon X convincing; to subscribe to "mental illness" is to find the psychoanalytic account convincing. The labels, then, are allegiances; not descriptions. I have argued that the Szaszian model is the more coherent of the two, and that what appears as confusion (the component that renders both labels unidentical) is largely the result of the psychoanalytic enterprise overreaching its proper scope. Lastly, using an analytical diagnostic approach, I propose a rearrangement that constrains the psychoanalytic enterprise to a scope it could reasonably uphold and in the case, it aspires to enlarge its scope, there ought to be justifications along each expansive step. In this way, categories are maintained and the medical enterprise does not overstep its area of expertise.

NOTES

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