The Moral Character of Mental Illness

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This paper offers a reimagination of Thomas Szasz's claim that mental illness is a myth. His idea that mental illness actually constitutes moral problems is expanded upon with a novel moral framework that makes the claim easier to grasp and advocate for. The argumentative strategy used is intended to bypass the major extant debate about the scientific validity or natural kind status of mental illnesses. Szasz's selective elimination of mental but not physical illnesses is vindicated via an epistemic reduction of the mental features to moral features, which does not parallelly obtain for physical features. This solution is optimised to address the criticisms of R.E. Kendell, arguably Szasz's foremost critic.

1 Introduction

The rejection of the psychiatric category of mental illness is often sloganised as 'mental illness is a myth'. This is credited to Thomas Szasz, who claimed that mental illness is not a legitimate category of illness in the way that physical illness is. He argued that 'mental illness' is a metaphor for moral problems, which have been mistaken for medical problems[1].

The aim of this paper is to reimagine Szasz's goal with an expansion on the morality claim that clarifies major criticisms of Szasz. I argue against two consensus ideas of mainstream psychiatry: first, that mental illnesses form a legitimate category of illness, and second, that they are distinct from mental responses that are expected and culturally sanctioned responses to external factors, in that they must arise from a dysfunction in the individual. The second idea is the DSM definition of mental illness, its most influential understanding[2]. This is the definition of mental illness I will attribute to the opposing view, and seek to refute. If I am successful in dispelling it, the rejection of the first idea should follow.

I argue that the concept of mental illness tracks something belonging to the moral realm. This realm is populated with other conditions not of clinical interest; 'mental illness' is not unique or meaningful as a category. The claim, then, will turn out to be true if there are insufficient grounds (metaphysically or epistemically, as will be seen) for identifying mental illness as a subset of the set of moral problems. I do not commit to all tenets of Szasz's thought – the goal is only to uphold the non-status of mental illness.

The plan for the paper is as follows. Section 2 reviews core ideas of Szasz with associated remarks (not exhaustive of either Szasz or his critics, but sufficient for this paper). Section 3 evaluates Hanna Pickard's defence of Szasz, which is of partial interest to this one. Section 4 suggests a moral framework informed by Aristotelian ethics that better captures Szasz's argument. Sections 5 provides a proposal that recasts illness on a moral dimension, denying that it is a meaningful metaphysical category. Section 6 then elucidates how the discriminatory elimination of just mental illness can be achieved without relying on metaphysics. This is done in addressing R.E. Kendell's challenge to Szasz, with a discussion of Szasz's response and how it is vindicated on the presently suggested conception of morality. Section 7 considers objections to the argument, especially clarifying the argument in section 6.

[1] Thomas S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, New York: Harper and Row, 1974.

[2] Eric J. Dammann, " "The Myth of Mental Illness:" Continuing controversies and their implications for mental health professionals" *Clinical Psychology Review* 17, no. 7 (1997), 738.

2 Szasz's ideas and their criticisms

2.1 The illegitimacy of mental illness as a category

Szasz's primary interest is the exclusivity of the concept of illness to physical conditions[3]. He believes that illnesses are fundamentally bodily, such that calling a mental condition an 'illness' is necessarily metaphorical. Illness requires a physiological deviation like a lesion[4]. Mental 'illnesses' are also deviations, but not from anatomical and physiological norms. Instead, Szasz considers them psychosocial and ethical deviations, since they lack the physiological deviations that constitute illness.

Several critics believe that these ideas are, essentially, Szasz (unscientifically) 'raising the spectre of dualism'[5], by discriminating mind and body. In response, Szasz explicitly denies Cartesian dualism[6]. The problem is not dualism itself; Szasz would not deny that physical illness can also cause mental suffering. Rather, he denies that mental conditions in particular should similarly fall under both categories simultaneously. If a so-called mental illness turns out to have a physiological correlate, he considers it a physical illness like any other, eliminating the concept of mental illness. Hence, Szasz willingly concedes that physiological correlates would legitimise mental conditions as illness[7].

The real problem with this argument, according to one of Szasz's most prolific critics, R.E. Kendell, is that mental features are frequently considered essential features of *bodily* illness. *No* illness is purely physical, because no illness acknowledges the mind-body distinction. Pain and suffering are as characteristic of somatic diseases as mental ones. Kendell holds that it is neither minds nor bodies but *people* who become ill[8] [9]; the prevalent conception of disease is in terms of suffering and functional impairment, transcending mind-body dualism. Szasz's conception is naïve and unfaithful to how the concept of disease has always been used.

Surprisingly, Kendell does not use this to defend psychiatry's legitimacy as equal to medicine's – he goes the other way, and inflates Szasz's stance to say that physical illness, in these terms, is just as meaningless and mythical a concept as mental illness[10] [11]. Though perhaps used as a *reductio* to demonstrate the unfeasibility or triviality of Szasz's position, I consider this possibility sincerely in Section 6.

2.2 'Problems in living'

A keen observer of legal and civil implications of psychiatric beliefs, Szasz did intend *methodological* dualism[12], believing that bodily disease and mental suffering should be dealt with differently. This arose from his belief that the subject-matter of mental illness is moral, not medical, because it refers to 'problems in living' that naturally populate the human condition. Psychiatry's pathologisation of these problems is the 'institutionalised denial of the tragic nature of human life'[13].

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[3] Ibid., 734.

[4] Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*.

[5] Dammann, " "The Myth of Mental Illness:" Continuing controversies and their implications for mental health professionals," 737.

[6] Brendan D. Kelly et al., "The Myth of Mental Illness: 50 years after publication: What does it mean today?" *Irish Journal of Psychological Medicine* 27, no. 1 (2010), 36.

[7] Hannah Pickard, "Mental illness is indeed a myth," in *Psychiatry as Cognitive Neuroscience: Philosophical Perspectives*, ed. Matthew Broome and Lisa Bortolotti, New York: Oxford University Press USA, 2009, 85.

[8] Robert E. Kendell, "The nature of psychiatric disorders," in *Companion to Psychiatric Studies*, ed. Robert E. Kendell and Andrew K. Zealley, Edinburgh and London: Churchill Livingstone, 1993.

[9] Robert E. Kendell, "The Myth of Mental Illness," in *Szasz Under Fire: A Psychiatric Abolitionist Faces His Critics*, ed. Jeffrey A. Schaler, Chicago, Open Court, 2004, 40-42.

[10] Ibid., 41.

[11] Mark Cresswell, "Szasz and His Interlocutors: Reconsidering Thomas Szasz's "Myth of Mental Illness" Thesis" *Journal for the Theory of Social Behaviour* 38, no. 1 (2008), 38.

[12] Kelly et al., "The Myth of Mental Illness: 50 years after publication: What does it mean today?", 41.

[13] Thomas S. Szasz, "Diagnoses are not diseases" *The Lancet* 338, no. 8782-8783 (1991).

Szasz believed that psychiatry 'thingifies' people, treating mentally ill people like defective machines[14], and 'presumes them to be incompetent'[15]. The worry is that literal interpretation of an intended metaphor downplays the moral nature of conduct: someone's behaviour is a deviation from ethical norms so significant that it is *reminiscent* of the deviations in illness – 'they acted *as if* they were mentally ill'[16].

However, Szasz also espouses some extreme views[17]: he holds that people are *always* responsible for their behaviour, with no acts being involuntary. He also does not consider the treatment of problems in living to be the unqualified business of psychiatry or medicine. These positions are increasingly indefensible with the progress of psychiatry, but seem to invariably arise from complete commitment to methodological dualism, on which moral issues should never be approached physically. My proposals will, therefore, seek grounds on which conditions we call mental illnesses can still sometimes or somewhat be helped by interventions we call psychiatric treatments, while nonetheless denying that we should (thus) distinguish mental illness as a category.

3 Pickard's 'tracking' tactic

Hanna Pickard aims to vindicate Szasz by entirely circumventing the debate about the meaning of illness and the status of mental conditions as valid scientific kinds. She hypothesises the discovery of a neurophysiological correlate for schizophrenia reliable enough to make it the basis for diagnosis, much like many bodily illnesses. Upon then finding a subject who has the 'schizophrenia lesion' but lacks any schizophrenic symptoms, we would be inclined to say that the subject has schizophrenia, perhaps of a 'latent' kind as opposed to a 'full-blown' kind. But we would not intuit that the subject is *mentally ill*, and she does not deviate from 'psychosocial and ethical norms'. The argument is that the concept of 'mental illness' tracks superficial symptoms, as opposed to underlying scientific properties[18]. By 'underlying scientific properties', Pickard refers to material constituents of a condition, meaning that the tactic is to claim that what we think of as mental illness comes apart from what we deem valid scientific kinds. This tactic appears useful to my aim, since delegitimising mental illness as a category will inevitably, and as a minimum, require what Pickard calls 'scientific validity' (that is, physiological correlates) to not automatically provide indisputable basis for formal categorisation.

The caveat is that Pickard's tracking selection is vulnerable to Kendell's objection to Szasz's alleged dualism. She claims that mental illnesses track deviations from ethical norms, but also includes psychosocial deviations, referring to 'superficial or personal-level symptoms' like 'mental distress', which presumably includes mental pain and suffering. This is the opening for Kendell's view to delegitimise Pickard's basis for distinguishing mental illness as tracking superficial symptoms rather than underlying scientific properties. The superficial symptoms are an essential feature of the consensus nature of illness, which Pickard does not contest because of her intention to evade that debate. Yet, she tracks a feature that does not escape that debate, so her view collapses the distinction between physical and mental illness just as Kendell predicts. So, a tighter conception of what mental illness tracks is needed.

4 'Moral deviation'

This section provides a novel moral framework for Szasz's envisioned 'moral character' of mental illness. The definition outlined is to be slotted in to Pickard's 'tracking' tactic to improve its viability.

[14] Thomas S. Szasz, *Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man* (London: Morion Boyars Publishers, 1973).

[15] Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*.

[16] Theodore R. Sarbin, "On the futility of the proposition that some people be labeled "mentally ill" " *Journal of Consulting Psychology* 31, no. 5 (1967).

[17] Thomas S. Szasz, *Law, Liberty and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices*, London: Routledge and Kegan Paul, 1963.

[18] Pickard, "Mental illness is indeed a myth", 87.

In the Greek tradition, eudaimonia, understood as 'flourishing' or 'wellbeing', was considered the highest human good and the goal of human life. The latter aspect is salient in Aristotle's thought: flourishing is the purpose of life, fulfilled through living in accordance with virtue[19]. Building off of this, Aristotle places the so-called pathological on a continuum with the normal, whereby possession of mental 'health' is virtue, and possession of mental 'illness' is vice, intended as inflationism ('mental illness' is just an instantiation of vice)[20].

Additional to this is ethical egoism, which states that people should pursue their own welfare[21]. This grounds the good in what is best for oneself as per the criteria determined by the human condition. Whether Aristotle himself assumed or intended egoism is controversial[22]; those who believe he did not can take me to be coopting egoism into eudaimonia for my view.

The views outlined, together, more clearly capture Szasz's belief that mental illnesses are moral problems[23]. The deviancy of the crazed, psychotic man who kills his ex-wife is easily identified on conventional morality. But it seems unreasonable on the lay view to recognise a moral deviation in the depressed or the traumatised, whose conditions can cause suffering restricted to themselves. That view only becomes sensible once 'moral deviations' mean phenomena against the wellbeing of oneself. Hereon, 'moral deviation' means 'anti-flourishing mode of being'.

5 The moral subject-matter of mental illness

The proposal, now, is this: all problematic mental conditions, those currently considered illnesses and those not, are united under the underlying category of moral deviations. This is the category the concept of mental illness tracks; 'mental illness' is not a distinct, unique category. Replicating Pickard's aim, this bypasses the debate about the scientific validity of mental illness, the answer to which is a strictly explanatory addition (of considerable utility, to be sure) to *some* items in the moral dimension. If mental illnesses turn out to be valid scientific kinds, we have a more detailed explanation of the cause (and possibly, treatment) of the moral deviation. But this does not affect the account of what these problems are, foremost.

The remainder of the argument is explained through examples of major depressive disorder (MDD) and generalised anxiety disorder (GAD), selected for their prevalence, but also because they may be relatively difficult, otherwise, to term moral problems.

MDD has been defined behaviourally, neurophysiologically and even phenomenologically[24]. All of these are equally tangential to this subject; they only scientifically characterise the nature of depression insofar as it exists as such a category. The idea here is that there is a morally relevant biconditional for problems in living, and what the construct of depression is tracking, scientific or otherwise, is a subset of the latter. The reader might interpret my claim to simply be that mental illnesses are functional kinds. My intention, though, is to allow a condition to exist simultaneously on material and moral accounts, so that it can *additionally* be a scientifically valid kind; the claim, however, is that the identification of the condition as a construct *at all*, *in any regard*, is in virtue of its partaking of the moral dimension – the moral aspect has priority over the physical because it is what informs the formation of the category as a problem.

[19] *Nicomachean Ethics* 1098a16.

[20] Edward Harcourt, "Aristotle, Plato and the anti-psychiatrists: Comment on Irwin," in *The Oxford Handbook of Philosophy and Psychiatry*, ed. Fulford et al., New York: Oxford University Press, USA, 2013, 47.

[21] Robert Shaver, "Egoism," *Stanford Encyclopedia of Philosophy* (Spring 2023 Edition), accessed November 28, 2023, https://plato.stanford.edu/archives/spr2023/entries/egoism/.

[22] Tom P. Angier, "Aristotle and the Charge of Egoism" *The Journal of Value Inquiry* 52, no. 4 (2018).

[23] The remainder of this paper does not rely on the endorsement of a view as esoteric as egoism; it simply lends itself well to the point being made. Similar conclusions can be extracted on branches of virtue ethics, like Aristotle's, which identify a state of mental wellbeing with the right mode of existence, or normative theories that require the upkeep of oneself as an end rather than a means. Fundamentally, the improperness of the condition must not be grounded in contingent consequences like harm caused to the subject's loved ones, because that has reduced scope and tracking reliability.

[24] Cecily M. Whiteley, "Depression as a Disorder of Consciousness" *The British Journal for the Philosophy of Science* (2021).

So, depression is caused by the occurrence of certain personal events that disturb flourishing *such that* symptoms like low mood and self-esteem, or the phenomenological change described by Whiteley, are produced. It is not just because suffering offends the human purpose of flourishing that the depressed are morally deviant; their suffering itself is evidence of the occurrence of moral deviations in their history. Here is a development in the point made in Section 2.2. Depression does not inexplicably emerge, suddenly victimising a subject such that observers can only sympathise with her misfortune for having contracted it. It carries an extensive causal history, but is only considered of clinical interest when the buildup of this process crosses a diagnostic threshold. Such a distinction fails to appreciate the core of the condition. Depression is the consistent departure from what promotes the anti-thesis of a (clinically relevant) depressive state, such this state is sanctioned by the mind[25].

Therefore, the DSM definition of mental illness is incorrect to differentiate 'proportionate' responses sanctioned by environmental factors and seek a dysfunction sourced in the individual. What psychiatry retroactively deems a dysfunction is just as proportionate a manifestation as any other. Every other problem in living possesses a symmetrically robust and available explanation. The gap is only in human ability and willingness to articulate the explanation. An omniscient examiner of how the depressed have come to be depressed would be more surprised if they did *not* culminate in precisely their present condition.

Next, consider two people, Robert and Evan. Robert is a chronically lazy person, who wastes away and refuses to develop himself out of aversion to exertion. Evan is a diagnosed patient of GAD, who has comparable behavioural maladaptations but exhibits them out of a debilitating worry for failure and change, typical of his cognitive patterns. We have superior epistemic coverage of Evan's case by virtue of the clinical interest we take in it, while Robert's is relegated to more abstract and informal self-help remarks. However, both suffer moral problems.

Robert and Evan are similar in that they are both in a state of character that is against their flourishing, but also in that these states are evidence of a historical departure from what would have made their life go well. Evan's symptoms, whether cognitive patterns like repetitive worrying and feeling overwhelmed, or emotions like fear, insofar as they are expressive of certain damaging prior experiences he had, are akin to Robert, whose sloth is a reflection of some other feature of his character. They both have reasons, and these reasons are problems not with particular mental configurations (which are symptoms, not causes) but concerning what is good of and for a person.

It might be asked why we cannot go the other direction and say Robert has an undiagnosed form of anxiety, or something similar. However, the present line of reasoning should skew us in this direction. If it is accepted that most problems in living are fundamentally orchestrations of mundane and non-pathological events, it is naturally contrived to package and promote each of them with labels that imply pathology or distinct categories of dysfunction. Similarly, it is not that non-material psychiatric interventions like talk therapy cannot ever help subjects. We should think, rather, that to the extent they are efficacious, they are doing in essence what self-help media does for Robert, just in a more sophisticated and systemised manner.

It is also not that selective systemisation of conditions betrays the fact that some conditions uniquely benefit from it in a way that qualifies them as meaningfully distinct in *nature* to moral problems. It is simply that some moral problems have a perceived degree of complication (for example, pattern-following cognitive symptoms) that are thought to require a corresponding degree of sophistication and organisation in interventions attempting to remedy them[26]. But as has been argued, this difference in degree does not qualify as dysfunction; mental symptoms must not be conflated with the underlying problem. Clearly, then, it must also be answered why we should uphold this conception of mental symptoms as mere instrumental details in what are essentially moral problems, while not upholding the same reductive view for physical symptoms in bodily afflictions. The following sections address this.

[25] Insofar as it is not the product of a neurochemical issue – I address this in section 6 and in objection 1 in section 7.

[26] Though I cannot undertake it here, there is also an additional possible argument here that this degree of systemisation and formalised intervention is less necessary to remedy mental illnesses than physical illnesses, in that medicine is largely the only possible cure for somatic diseases, while psychiatry is much less decidedly the sole solution for mental suffering.

6 Explanatory construction

I now address the interaction of Kendell's objection with my view, explain why it avoids Pickard's trouble, and clarify Szasz and Kendell's positions to shed new light on the debate.

I have given my tracking slot to moral deviation instead of suffering, since suffering is a feature of all illness and hence not grounds for eliminating only mental illness. However, this move initially appears to have achieved nothing. The reason is that, especially given my 'anti-flourishing' concept of morality, a conditional is obtained with suffering as the antecedent and moral deviation as the consequent. If suffering always invokes morality, and suffering is as characteristic of bodily illness as it is of mental illness, then we apparently fail again to differentiate between the two.

My response is to bite the bullet, because, as I now show, the 'suffering' matter is something that all parties involved must and *do* concede, but it is not what my or Szasz's argument needs to rest on – only Pickard falls victim.

Szasz never denied that physical illnesses also constitute problems in living (see Section 2.1). He understood that the concept of illness, even if strictly physical, implicates moral deviation, since it involves judgement that suffering is bad for oneself. His point was not metaphysical but epistemic: 'although the desirability of physical health, as such, is an ethical norm, what health is can be stated in anatomical and physiological terms'[27]. What he meant is that physical deviations form an intelligible and useful category uniting some members of the set of moral deviations. If the connection to physicality is relaxed, the reference of illness becomes interchangeable with generic problems, and the word loses its meaning. *That* is why he restricted illness to physicality. Szasz really was not a substance dualist; he was motivated by methodological dualism, believing that it serves mental sufferers better to interpret their condition as moral rather than illness. That this was his intention is evidenced in his simple reply to Kendell: 'I disagree. The "concept of physical illness" demarcates a category… Every concept or idea can be used or abused, help people or harm people.'[28]

So, Szasz intended what I argued in Section 5 about non-moral facts being explanatory constructs, differing only in denying that they can be relevant to treating mental conditions. Bizarrely, Kendell expressly agrees about explanatory construction: 'For most of human history, disease has been essentially an explanatory concept, invoked to account for suffering'[29].

The reason Kendell did not then reach the same conclusion as Szasz was because he took mental features to be explanatorily significant. Suffering has neural correlates, which no one in this debate would deny – none are dualists. But Kendell thinks suffering only explains the problem when construed in its capacity as a mental feature. The DSM thinks likewise: it is not bold enough to adopt dualism, yet asserts psychological processes as essential constituents of mental illnesses alongside biological processes, not acknowledging that the former is ostensibly reducible to the latter[30].

So, no one is arguing metaphysics here – the disagreement is about our epistemic decisions. Finally, my proposal vindicates Szasz's intention: having assumed illness to be an explanatory construct, I claim that moral features are *better explanations* of suffering than mental features (which is the departure from Kendell) – and I have already argued for precisely this in Section 5. Additionally, we preserve physical illness; (using Szasz's point) physical explanations are still useful to explaining *some* moral deviations (see Objection 1 for clarification). Consequently, mental illness alone is eliminated.

The explanatory reduction of the psychological to the physical is demonstrable in any disorder where phenomenological or cognitive symptoms are caused by lesions. It goes through straightforwardly because the opposition also promotes physical explanations; I am seeking to replace

[27] Szasz, *Law, Liberty and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices*.

[28] Thomas S. Szasz, "Reply to Kendell," in *Szasz Under Fire: A Psychiatric Abolitionist Faces His Critics*, ed. Jeffrey A. Schaler, Chicago, Open Court, 2004, 54.

[29] Kendell, "The Myth of Mental illness," 31.

[30] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (Washington: American Psychiatric Publishing, 2013).

only the mental (with the moral). That reduction goes through because Kendell was incorrect to think that it is the mental formulation of suffering that makes it relevant. It is apprehended as a mental phenomenon, but only qualifies as a relevant criterion by virtue of moral deviation being its consequent.

Also, as argued in Section 5, mental deviations in conditions like depression or anxiety are often eventualities orchestrated by a massive sequence of micro- or macro-events related to the human good. Where they are instead closer to having apparently 'dropped from the sky', the explanation is likely to be biological/neurophysiological, invoking the first category. The idea is that physical and moral features are *jointly* sufficient to eliminate mental features as meaningful representatives of moral deviation, such that mental features are always symptomatic of deviations in another category.

7 Objections and replies

Objection 1: Even if the mental to physical explanatory reduction goes through, the mental to moral move is dubious. Mental features like emotions and beliefs, barring ones symptomatic of neurophysiological defects, directly generate 'anti-flourishing', and hence the mental category remains the best explanation of the condition.

The answer to this this was teased out in Section 5, but bears restating. It is true that somatic and neurophysiological, as well as cognitive (assuming suspension of the notion that cognition is reducible to neurophysiology anyway) deviations, can all create moral deviations. The argument, however, is not targeting contribution to anti-flourishing, but being manifestative of anti-flourishing. In this regard, physical afflictions are distinct from mental ones.

Bodily illnesses warrant acknowledging and isolating as an explanatory category because they are 'starting points': a lesion can cause suffering (→moral deviations), but its acquisition is unrelated to the moral dimension, and arbitrary in that sense. Meanwhile, mental features that constitute suffering, such as those in mental illnesses, cause moral deviations but are themselves existent due to a prior moral deviation. Because they are reflective of moral features, their subject-matter is best explained and understood as a straightforward moral problem.

Compare Evan's GAD to an athlete who contracts a disease that sidelines him, damaging his career. Evan's suffering is reflective of something that happened to him that was against the human good; perhaps he was bullied or abused in childhood. The mental features are only responses sanctioned by the experience of suboptimal life events. The athlete, meanwhile, experiences moral disruption due to something that cannot be explained morally in the first instance (changes to his body).

Of course, GAD potentially has a genetic component, just as several mental afflictions are potentially influenced by neurochemical issues. That is why the reasoning for the elimination of mental features as an original explanation is an *inclusive disjunction* of physical and moral features. This is also where my view is advantageous over Szasz's *exclusive* disjunction, which does not allow for a condition to be explained partly physically and partly morally – we are reluctant to treat depression, for example, as a mere brain disorder like dementia, but do not want to rule out material influences on it.

Objection 2: In Section 5, you criticised psychiatry's practice of labelling moral problems 'illnesses' simply because they outwardly crossed a diagnostic threshold. However, this practice is commonplace in medicine for conditions that are clearly illnesses, like diabetes.

Because, as Kendell notes, illness is a pragmatic construct, the crossing of a quantitative threshold rather than the undergoing of a qualitative change is indeed a staple criterion of medical diagnoses. However, the difference is that in medical cases, the phenomenon only begins infringing on one's wellbeing *after* crossing the diagnostic threshold, which is why the threshold's placement is legitimate. In the case of depression that I argued for in Section 5, the threshold is crossed in the first place *because* flourishing was disturbed. Therefore, illness (insofar as that term alludes to a physically observable metric) is the better explanation for diabetes, but morality remains the better

explanation for depression (as opposed to mental features; to reiterate, I do allow physical features as a coexistent and meaningfully distinct explanation).

Objection 3: Unlike Szasz, you concede that the subject-matter of 'mental illnesses' can be, partially, of medical relevance. So, your conclusion is trivial, or simply a pedantic reflection on human suffering.

The progress of psychiatry has made it simply incorrect to claim that medical interventions are never of use. The hope with this paper is not to dispose of all psychiatric interventions for problems in living, but to clarify how problems are best understood, and hence, treated. Meaning, I retain Szasz's methodological dualism only partially, because full commitment generates untenable positions.

My view avoids Szasz's conclusion that people are always responsible for their conduct. To the extent that a moral deviation is better explained physically, we can absolve individuals of responsibility. Of course, it is still a moral deviation – morality and agency come apart on the 'anti-flourishing' conception, which tracks the set of moral patients, not the set of moral agents.

However, mental conditions explained *more* as moral deviations than physical deviations should be interpreted *primarily* as indications that the subject's life is not conducive to her well-being, rather than pinning the suffering on a disorder, an additional entity. People have excellent reasons for being depressed, anxious or traumatised, and eagerness to alleviate behavioural symptoms/manifestations (due to perception of the issue as consisting in mental symptoms rather than a deeper moral problem) via medication or even therapeutic intervention may sometimes overlook the root cause. Any 'dysfunction' spoken of should be metaphorical, and with respect to the patient's life.

8 Conclusion

Szasz argued that mental illnesses constitute moral problems and not scientific constructs like disease. He was pegged as a substance dualist illegitimately discriminating against mental illness. I have combined Pickard's 'tracking' tactic with a novel conception of morality to argue in defence of Szasz's intention. I have claimed that all illness is manifestative of moral deviation *qua* suffering, but that distinctions are possible on epistemic grounds. Mental features are considered essential to the explanation of illness, but they are better explained in either physical or moral terms, such that the only categories required are 'illness', which is physical, and moral deviations. The former remains a subset of the latter, allowing a departure from Szasz's strict methodological dualism, which invited the criticisms he drew. Barring that, Szasz is misunderstood, and quietly insightful in claiming that mental illness is a myth.

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