On The Myth of Psychotherapy*

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To appear in *Philosophy, Psychiatry, & Psychology*

Abstract: Thomas Szasz famously argued that mental illness is a myth. Less famously, Szasz argued that since mental illness is a myth, so too is psychotherapy. Szasz' claim that mental illness is a myth has been much discussed, but much less attention has been paid to his claim that psychotherapy is a myth. In the first part of this essay, I critically examine Szasz' discussion of psychotherapy in order to uncover the strongest version of his case for thinking that it is a myth. As we'll see, this involves an understanding of psychotherapeutic interventions as treatments of psychopathological problems. In the rest of this essay, I turn to this directly and argue that psychotherapy has an important non-pathocentric dimension. I argue that we fail to appreciate the nature and variety of psychotherapy if we concentrate only on its pathocentric dimensions. Though I use Szasz as a stalking horse, the substantive topic is the nature of psychotherapy. This enquiry falls into the philosophy of psychotherapy as distinct from the philosophy of psychiatry and the philosophy of psychoanalysis.

Keywords: psychotherapy, psychopathology, Szasz, grief

* Acknowledgements: Many thanks to two anonymous referees for this journal for very thoughtful comments that helped me to improve the paper. For extremely helpful comments on previous drafts, thanks to Helen Bailey, Will Davies, Anil Gomes, Chris Jay, Ian Kidd, Ian Phillips, Louise Richardson, and Sam Wilkinson. An early version of this material was presented at the *Mind, Mental Health, and Epistemic Injustice* workshop at the University of Nottingham in July 2022, thanks to the audience for helpful feedback. This research was generously supported by a British Academy/Leverhulme Trust Small Grant: SRG2223\230257.

1. Introduction

Thomas Szasz (1960) famously argued that mental illness is a myth. But if mental illness is a myth, what of psychotherapy? Less famously, Szasz argued that since mental illness is a myth, so too is psychotherapy (Szasz, 1974, 1988). Szasz' claim that mental illness is a myth has been much discussed. Less attention has been paid to his claim that psychotherapy is a myth. In the first part of this essay, I critically examine Szasz' discussion of psychotherapy in order to uncover the strongest version of his case for thinking that it is a myth. As we'll see, this involves a certain understanding of psychotherapeutic interventions – that they involve the treatment of psychopathological problems. In the rest of this essay, I turn to this claim directly and argue that psychotherapy has an important non-pathocentric dimension. Our substantive topic is thus the nature of psychotherapy. I suggest that we fail to appreciate the nature and variety of psychotherapy if we concentrate only on its pathocentric dimensions.

2. The Myth of Psychotherapy

Szasz' scepticism about mental illness is radical: it is the claim that there is no such thing as mental illness (Szasz, 1960, p. 113). Since Szasz is happy to interchange talk of mental illness with other pathological notions such as mental 'disease', mental 'disorder' etc., we can understand Szasz' claim in these terms: there are no genuine *psychopathological problems*, where we understand 'psychopathological problem' as an umbrella term to capture any psychological problems that are pathological. In claiming that there are no such problems, Szasz doesn't deny that we *classify* problems as psychopathological. He claims that these are *mis*classifications of what in reality are nothing more than 'problems in living' (Szasz, 1960, p. 118) – issues that are all to do with navigating ethical, social, and psychological norms, and nothing to do with pathology.

Szasz promotes a similarly radical scepticism about psychotherapy: '[t]here is, properly speaking, no such thing as psychotherapy' (Szasz, 1988, p. x). There *are* occasions where two or more parties engage in what is called 'psychotherapy', with outcomes that are labelled 'therapeutic'. But 'these coming-togethers... are not therapeutic' (Szasz, 1974, p. 213).

Szasz' central argument for this seems to be that it follows from the myth of mental illness:

> I've maintained that there is no such thing as mental illness... It is implicit in this view that there can also be no such thing as psychiatric diagnosis, prognosis, or treatment; in other words, that psychotherapeutic interventions are metaphorical treatments... (Szasz, 1974, p. 212; see also (Szasz, 1988, pp. xi–xii))

A natural reaction to this is to reject the highly contentious claim that mental illness is a myth.[1] But I'll accept this for the sake of argument, since I want to explore a different critique; one that will foreground a philosophically interesting topic: the nature of psychotherapeutic intervention.

Before we get to this, though, we need to reconstruct Szasz' argument, for there are two issues: first, Szasz is concerned with *psychotherapeutic interventions*, but also with *psychotherapy* – a certain kind of healing practice. And so Szasz makes *two* myth of psychotherapy claims, though he doesn't distinguish them:

> (MoP1): There is no such thing as psychotherapeutic intervention.
>
> (MoP2): There is no such thing as the practice of psychotherapy.

As we'll see shortly, these claims can come apart when we consider specific understandings of psychotherapy as practice, and psychotherapeutic intervention. I take it that Szasz accepts both, and sees them as closely connected, but getting clear on this will take a little unpacking.

The second issue is that Szasz' central argument as stated is not valid: for even if there are no psychopathological problems, this alone doesn't show that there is no such thing as psychotherapeutic intervention or the practice of psychotherapy. For there may be psychologically oriented ways of helping people that aren't concerned with psychopathology.

We can address both issues, I suggest, by excavating Szasz' assumptions about psychotherapy and psychotherapeutic intervention. This should help us to understand how the two myth of psychotherapy claims are closely connected, and also help us to understand how we can bridge the gap in Szasz' argument.

So, what *are* Szasz' assumptions? When it comes to psychotherapy, Szasz states that the 'conventional view' of psychotherapy is that it is the 'treatment of mental disease' by psychological means. This conception of psychotherapy is something Szasz finds support for in psychiatric textbooks and from psychiatric bodies (Szasz, 1988, pp. 3–5), and we find similar ideas in some of today's textbooks, e.g., Cutler, 2014, Chapter 17 and Marwick, 2019, Chapter 3. This conception reflects a pathocentric model of psychotherapy as a practice. With it, we can plug the gap in Szasz' argument for (MoP2): if there are no psychopathological problems, and psychotherapy is the treatment of such problems, then there is no such thing as psychotherapy.

However, this falls short of (MoP1). Since even if psychotherapy as a practice is a myth (because it is focused on psychopathological problems which don't exist), that doesn't necessarily mean that psychotherapeutic *intervention* is – for perhaps there can be psychotherapeutic interventions that are *not* focused on psychopathological problems. In which case, we could admit that psychotherapy as a practice (conceived in a pathocentric way) is a myth, even if we deny that psychotherapeutic intervention is.

If one is unconvinced of this consider the following analogy: suppose that a mathematics lecture is all about solving problem *M*. Does it follow from this that all of the important components of the lecture should be defined as *M*-solving components – as intrinsically directed at this problem? No. Some of them may be. But some of them may be tools or techniques that are more general (e.g., mathematical procedures which could be invoked for many problems), or less general but not intrinsically *M*-focused (perhaps their applicability to *M* comes only when combined with other tools). Likewise, even if the practice of psychotherapy is pathology-treatment focused, it doesn't follow that specific psychotherapeutic interventions are.

Perhaps, then, Szasz is making an assumption about psychotherapeutic *intervention*, namely: that psychotherapeutic interventions are a matter of psychologically oriented treatments of psychopathological problems. With this, Szasz can argue that since there are no psychopathological problems, and since psychotherapeutic interventions are simply treatments of such problems, then there is no such thing as psychotherapeutic intervention.

But don't we now have one argument for (MoP1), and another for (MoP2)? How can this help us to appreciate how these claims are connected? I think we can make sense of all this by taking Szasz' fundamental claim to be (MoP1), and by taking the fundamental driving force of his argument (alongside the myth of mental illness) to be the pathocentric model of psychotherapeutic *intervention*. We can display this structure by reconstructing his central argument as follows:

1. Psychotherapeutic intervention is a matter of psychologically oriented treatment of psychopathological problems.
2. There are no psychopathological problems.

Therefore,

3. There is no such thing as psychotherapeutic intervention (MoP1).
4. If (MoP1), then there is no such thing as psychotherapeutic practice (MoP2).

Therefore,

5. There is no such thing as psychotherapeutic practice (MoP2).

Now, if we have a very *attenuated* sense of what it is for there to be a practice of psychotherapy, then we can reject (4). In this sense, there being a practice of psychotherapy is just a matter of there being goings-on which get called 'practicing psychotherapy'. And obviously there is psychotherapy in this sense, even if there are no genuine psychotherapeutic interventions.

However, I take it that Szasz understands the practice of psychotherapy in a fuller way, wherein practicing psychotherapy necessarily involves the use of genuine psychotherapeutic intervention. In this fuller sense, (4) holds. For if there are no psychotherapeutic interventions, and psychotherapy as a practice requires psychotherapeutic interventions, then there is no such thing as psychotherapy as a practice. Compare: there may be a practice of witchcraft in the attenuated sense of goings-on that get called 'witchcraft', but if there is no such thing as magic, and witchcraft in a fuller sense is a practice that involves magic, then there is no such thing as witchcraft in that sense.

This way of reconstructing Szasz' argument addresses the issues we raised above: for it allows us to make sense of how the two myth of psychotherapy claims are closely connected: (MoP1) entails (MoP2). And it allows us to plug the gap in Szasz' argument: for it fully articulates the assumption about the nature of psychotherapeutic intervention concealed in Szasz' crude formulation.

This brings into focus our central topic: the nature of psychotherapeutic intervention. What should we make of the pathocentric model of psychotherapeutic intervention? In what follows, I argue that we should reject it. I'll then discuss the significance of this for our understanding of psychotherapy.

3. Against the Pathocentric Model

3.1 Outline of the Argument

I'll argue that there are many psychotherapeutic interventions that are *not* a matter of treating psychopathological problems. One argumentative approach consistent with this is *modality-centric*. It involves highlighting modalities of psychotherapy which don't have psychopathology at their heart. Sanders, 2018, for instance, sees the principles of *person-centred therapy* as in conflict with the medicalisation of psychotherapeutic intervention – for its focus should be the whole person and *not* medical disorders they may be thought to have.[2]

But the argument I'll develop is more general: I'll argue that the model fails to characterise various interventions in various modalities, even interventions associated with modalities which sometimes place a stronger emphasis on pathology, such as traditional forms of cognitive behavioural therapy.[3] The argument is *topic-centric*: it focuses on the subject-matter of psychotherapeutic interventions – the sorts of things that psychotherapeutic interventions concern. The argument has two stages. First, I argue that there are a range of psychological problems that people may present with in psychotherapy, but which are non-pathological

(§3.2), and second, I argue that such problems can be addressed by psychotherapeutic intervention (§3.3).

3.2 Non-Pathological Problems in Living

Consider problems with anger, guilt, shame, loneliness, grief, heartache, stress, confidence, identity, sexuality, relationships, etc. There are many issues that fall into these categories that are psychologically painful, distressing, and debilitating, where psychotherapy would be an appropriate means of support, but which are non-pathological.

Now, setting aside Szaszian animadversions to psychopathology, there may be issues in these categories which *are* pathological – e.g., problems with stress that reflect an anxiety disorder. Even so, the point is that there can *also* be problems within these categories, which people seek psychological support for, which are *not* pathological. For instance, consider someone living in a homophobic society, suffering from feelings of shame about their homosexuality. Their feelings interfere with their life to such an extent that they seek psychotherapeutic support. Yet there need be no *disorder* here.

Such problems, I take it, would not count as pathological on prominent *accounts* of disorder (for helpful discussion, see Cooper, 2002 and Wilkinson, 2022, Chapter 2). However, such accounts are not my focus here. I rely instead on the fact that there are a range of such problems which are regarded as non-pathological in our everyday and clinical classifications: a range of psychological problems which it is appropriate to seek psychotherapy for, but which are ordinarily regarded as non-pathological, and which do not figure in taxonomies which are supposed to capture psychopathological conditions, such as *The Diagnostic and Statistical Manual of Mental Disorders*, and the *International Classification of Diseases*. Such taxonomies are not without their issues.[4] Nonetheless, when a problem which we intuitively

treat as non-pathological also does not appear in such taxonomies, the purpose of which is to detail psychopathological conditions, that is (defeasible) evidence for its non-pathological status.

Relatedly, the idea that such problems are non-pathological is not the Szaszian claim that they are problems that *masquerade* as pathological, but in fact are merely non-pathological problems in living. On the contrary, the problems I am aiming to draw attention to are *manifestly* non-pathological.

Finally, in calling these psychological *problems*, I mean to suggest that they are difficulties or troubles for the individual. And so, like paradigmatic pathological conditions (e.g., heart disease) they are disvalued and unwanted. It is just that they are not difficulties constituted by or reflective of any pathology.

The first stage of argument, then, is that there are *non-pathological problems in living* which people may present with in psychotherapy. I'll argue now, by focusing on the case of grief, that people do receive psychotherapy for such issues.

3.3 The Psychotherapy of Grief

3.3.1 Relational Interventions

Consider the following case example offered by the integrative psychotherapist, Richard G. Erskine. Erskine describes the case of Ruth, suffering with compounded grief over the death of her 19-year old son in a car accident (Erskine, 2014, pp. 283–284). Various factors compounded Ruth's grief: she had to face the family of another victim. She had to face several legal responsibilities. And her ex-husband blamed her for their son's behaviour – he had been drunk whilst driving, and was prone to such behaviour. Erskine notes his 'therapeutic priority'

centred around Ruth's son and her relationship to him: his death, her experience of loss, qualities of their relationship, etc.

In treating Ruth, Erskine operated with the therapeutic principle that people suffering compound grief 'need to have a way to verbalize and physically express their grief to an interested and involved listener or the untold personal stories of loss may be expressed in physiological reactions, dreams, fears, and obsessions' (p. 280). The idea is that facilitating the client in such verbalisation and expression may help to ease some of the distress of grief, and address the privation that incomplete good-byes so often leave (p. 281). With this in mind, Erskine employed the approach of *interpersonal contact* with Ruth: he became an interested and involved listener, and created space for Ruth to verbalise and express what she needed to express. At every point, Erskine was *attuned* to Ruth. As he explains:

> The therapy of Ruth's grief was in our interpersonal contact. I was compassionate when Ruth was sad, I took her anger seriously, I expressed joy when she remembered precious moments with her son, and I felt protective when she expressed fears about the unresolved legal issues. Her emotions oscillated from despair and confusion to anger, sadness, resentment, more anger, further sadness, and finally to joy and appreciation... The intersubjective contact–Ruth's expression of each affect and my attuned responses–was essential in her finding some relief from her grief (p. 284).[5]

We'll return to the implications of this shortly, but first, let's consider some other categories of intervention.

3.3.2 Cognitive Interventions

Consider now the grief that can be experienced by someone providing home care for a loved one with dementia. As Meichsner, Schinköthe, and Wilz, 2016, pp. 231– 232 note, this is often

multifaceted. It can involve experience of loss in the present (such as when the personality of the loved one changes radically), but also *anticipatory* grief when the impending death of the loved one is salient (Rando, 1986). Such grief is often compounded by various factors (e.g., physical and psychological burdens of caregiving). It is intrinsically emotionally distressing, and if unaddressed, can lead to further mental and physical problems. Clearly, then, we can understand why a caregiver may benefit from psychotherapeutic intervention for such grief.

In a study of CBT grief therapy for caregivers, Meichsner and Wilz, 2018 focused in on the anticipatory (or 'pre-death') grief component. Their study involved a CBT manual specifically tailored to dementia caregivers, and it focused on the module: *Coping with Change, Loss, and Grief*:

> In this module, grieving is understood as a normal and appropriate reaction to caregivers' experience... the aims of the module were to (1) help caregivers recognize losses and changes, and (2) foster acceptance of the disease and the associated emotions. At the core of that, caregivers learned to cope with pre-death grief through management of painful emotions. That means that therapists conveyed how much caregivers can recognize, express, and accept emotions such as grief, sadness, loneliness, desperation, and anger, while maintaining their daily functioning as a caregiver at the same time. The module further comprises CBT-based techniques for identifying and restructuring dysfunctional cognitions regarding grief, redefining the relationship with the care recipient, activating resources, and preparing caregivers for the death of the care recipient (p. 219).

To illustrate further, when it comes to managing and accepting painful thoughts and emotions, therapists help clients to recognise and express the emotions that are avoided, and techniques here include 'psychoeducation and normalization to convey how acceptance can positively

affect well-being while avoidance can have negative consequences' (p. 220). When it comes to acceptance, they include 'mindfulness exercises that facilitate the conscious experience of painful emotions and their acceptance' (ibid). When it comes to helping clients to restructure dysfunctional thinking (e.g., the thought that it is not OK to grieve for a loved one who is still alive), the therapist will help with identifying assumptions, and developing helpful alternatives, using techniques such as 'psychoeducation and techniques of cognitive restructuring (e.g., Socratic dialogue)' (ibid).

The idea behind this is that some of the distress of the grief that caregivers are experiencing is scaffolded by various cognitive elements. And so it makes sense to employ therapeutic interventions focused on such elements, e.g., the level of understanding the caregivers have about their experiences and feelings, any problematic assumptions they might have, what the caregivers might be in a position to accept, etc. The cognitive interventions detailed above are of this sort.

3.3.3 Creative Interventions

Erskine's focus was on Ruth's *expressive*, *experiential*, *emotional*, and *relational* capacities, whereas the CBT interventions are focused on *cognitive* capacities. A final example I'll cover here are those that focus on *creative* capacities: capacities for imagination, pretence, role play, storytelling, narrative construction, writing, drawing, etc.

In a handbook on grief counselling and grief therapy, Worden, 2018, p. 173 explains how he has found the Gestalt therapy technique of the *empty chair* effective in grief therapy:

> I set up an empty chair in the office and have the patient imagine that the deceased is sitting in that chair. Then I have the patient talk directly to the deceased about his or her thoughts and feelings concerning the death and their relationship... This is a very

> powerful technique and is useful for completing unfinished business, handling guilt and regrets, and the like. You can increase the power of the technique by having the patient switch chairs and *talk for the deceased* as well as *to the deceased* (p. 173).

Part of the value of this technique, Worden explains, is to be found in having clients *talk directly* to the deceased in the present tense (albeit in a creative context). This can be more powerful to the client's progress through grief and mourning than them merely talking *about* the deceased.

3.3.4 Lessons

Neither Ruth's grief, nor the caregiver's pre-death grief are conceived of as *pathological* problems (by therapist or client). And there is no relevant entry for these problems of grief in diagnostic manuals. DSM-5-TR does list 'Persistent Complex Bereavement Disorder', and ICD-11 lists a similar condition known as 'Prolonged Grief Disorder'. But there is no evidence in the studies we have considered that our cases fit these classifications.[6] With respect to the caregivers, they are not dealing with bereavement. And though Ruth is dealing with bereavement, the DSM disorder requires grief symptoms to persist for at least 12 months, and the ICD disorder requires them to last for at least 6 months, but the problem for which Ruth sought treatment was grief in the immediate aftermath of her son's death.

So, even if 'grief' can sometimes be used to refer to a psychopathological condition, the discussions we have looked at reflect the fact that it can also have a non-pathological use. We can thus take the studies we have considered to provide additional support for the idea that we should recognise non-pathological problems in living.

Importantly, however, these studies also support the idea that such problems are *treated* in psychotherapy. Ruth's treatment is precisely what Erskine details: skilful, theory-based,

employment of interpersonal contact to help relieve some of the distress of grief. Similarly, what Meichsner and Wilz detail is precisely a *treatment* module. What they describe in spelling out the details of this is precisely the kind of CBT-based treatment the caregivers were given in their therapy, which helped them to cope with, understand, accept, and manage their thoughts and emotions, and which ultimately helped them to relieve some of the burden of grief.

Similarly, the empty chair technique can be used in treating someone who is struggling with grief. Though this technique may be applicable to pathological problems in grieving, there is nothing intrinsic to the technique which limits it to such problems. Perls, 1973, p. 65 relates the technique to bereaved clients who have things *unresolved* with the deceased. Similarly, Neimeyer, 2012, p. 266 notes how the technique can be useful for those 'burdened with "unfinished business" with the deceased, whether in terms of intense separation distress, anger, guilt or other issues, or who simply want to reorganize an ongoing bond with them of a more fluid and accessible kind'. These issues may apply to someone with a pathological form of grief, but they obviously may also apply to someone who is struggling with a non-pathological problem in grieving.

4. The Meaning of 'Treatment' and 'Therapy'

I've argued that there are non-pathological psychological problems, and that these are treated in psychotherapy. And so, the pathocentric model of psychotherapeutic intervention – on which psychotherapeutic interventions are a matter of psychologically oriented treatments of psychopathological problems – fails. In this section I'll consider a number of replies to what I've argued that centre, in one way or another, on the meaning of 'treatment' and 'therapy'.

First, note that Szasz will deny that the interventions I've been describing are genuine treatments. For he holds that 'psychotherapeutic interventions are metaphorical treatments'

(Szasz, 1974, p. 212). Indeed, 'if the conditions psychotherapists seek to cure are not diseases, then the procedures they use are not genuine treatments' (Szasz, 1988, p. xii).[7] He's assured of this, because he has a particular view of the literal meaning of terms like 'therapy' and 'treatment', thus:

> In this book I shall argue that treatment means, and should only mean, a physicochemical intervention in the structure and function of the body aimed at combating or curing disease. The term *psychotherapy*, insofar as it is used to refer to two or more people speaking and listening to each other, is therefore a misnomer, and a misleading category. Because it may help people, psychotherapy may be thought and said to resemble regular medical treatment; but it is not such treatment. There is, properly speaking, no such thing as psychotherapy. Like mental illness, psychotherapy is a metaphor and a myth (Szasz, 1988, p. x).

As a consequence of this, Szasz is in the uncomfortable position of having to say that people who claim that their problems (e.g., ordinary grief) are distressing but not pathological, and yet claim to have received genuine *therapy* for them, are at best speaking loosely. I think, however, that we should interpret such people more charitably. So how can we respond to Szasz' claims?

One issue here is that Szasz says surprisingly little to clarify what he means in describing psychological interventions as metaphorical therapies or treatments. One thing he does say is that 'psychotherapy, like mental illness, is a metaphor, *an expansion of the customary use of the word 'therapy' to cover things hitherto not meant by it*' (Szasz, 1988, p. 7, my emphasis). But it is not clear why this should indicate that when we speak of psychotherapy, we speak non-literally or metaphorically. It is, after all, customary in discussions of semantic change to distinguish cases of meaning expansion which aren't cases of metaphor. Some examples given by Campbell, 2013, p. 223 include, 'dog', and 'salary'. Originally, 'dog' indicated just a

specific powerful breed of dog, but over time its meaning grew to include all breeds. ‘Salary’ evolved from meaning a soldier’s allotment of salt, to a soldier’s wages, to wages in general. When we talk of a dog of a very different kind than that of the original breed as a dog, we *are* speaking literally and not metaphorically – the literal meaning has expanded. Similarly for ‘salary’.

These examples show that even if a use of a word is an expansion of a customary use to cover things hitherto not meant by it, this does not necessarily take us into the realm of the non-literal or metaphorical. Now, I am not positively claiming that ‘therapy’, insofar as it covers psychotherapy, *is* an example of a non-metaphorical expanded use – something that would require linguistic investigation. My point is simply that Szasz has done nothing to assure us that its use to encompass psychotherapy is *metaphorical*, rather than *mere* expansion.

But even setting aside these issues, there is a more basic flaw in Szasz’ argument: he doesn’t argue for, but merely asserts, its crucial ingredient: namely, his claim that terms like ‘therapy’ and ‘treatment’ have an exclusively pathocentric literal meaning. Why should we accept this? These terms do literally apply to medical interventions for diseases. But do they *only* refer to such matters? In light of the way these terms are *used* in everyday life (both in relevant practice, but also colloquially) this seems no more plausible than the idea that the term ‘dog’ excludes breeds of a kind that we now include, but that were not originally included.

In talking of therapy or treatment for non-pathological psychological problems, we might mean to talk of the skilful, psychologically oriented, theory-based, helping, supporting, or nurturing of people with these problems (for instance, to helping them to overcome them, manage them, understand them, control them etc). We might mean to talk of helping people to relieve or manage psychological pain and suffering. And we might mean to talk of helping people to deal with (e.g., control, modify, accept, etc) behaviours associated with these problems. In everyday

life, we comfortably describe such endeavours with the terms ‘therapy’ and ‘treatment’. In the absence of any argument that the literal meaning of these terms cannot accommodate this, we should take this as evidence that the literal meaning of these terms is *not* restricted in the way that Szasz speculated. Just as we can speak of problems in living without intending any pathocentric focus, so too can we speak of therapy and treatment for such problems.

One final consideration from Szasz is that since ‘psychotherapeutic procedures consist of nothing but listening and talking, then they constitute a type of conversation which can be therapeutic only in a metaphorical sense’ (Szasz, 1988, p. xii). Now, even if we accept Szasz’ impoverished understanding of ‘treatment’ and ‘therapy’, it is not obvious that Szasz has a point here: for some understand psychotherapeutic interventions as interventions that ‘tap into processes that build and modify neural structures within the brain’ (Cozolino, 2017, p. 27), and so as similar to pharmaceutical treatments. The response I want to develop, however, is that Szasz’ characterisation of psychotherapeutic procedures as involving *nothing but* talking and listening is grossly inadequate.

First, we should recognise the role of non-verbal communication in the therapeutic process. In general, we “say” so much with our faces and bodies. And our emotional connection with others goes way beyond exchanges of words. Relational therapeutic interventions which foreground the relationship between client and therapist will likely involve these non-verbal elements. For instance, consider the importance Erskine places on *attunement* in the interpersonal contact intervention he employed with Ruth. His attunement to Ruth involved more than verbal transaction. As he says, ‘I hoped that she could see the compassion in my eyes’ (p. 284). Erskine emphasises that for Ruth, ‘the healing was in the quality of the relationship’ (p 284), and we can add: there was so much more to the quality of that relationship (and such therapeutic relationships generally) than what can be captured in verbal exchanges.

Second, consider psychotherapy involving the empty chair technique. Is this simply a matter of listening and talking? It is surely not *simply* this. A client supported with this technique is *acting*, and in some sense *performing* or *role* playing – there is more to these things than merely talking and listening.

Finally, and relatedly, Szasz' idea that psychotherapeutic procedures consist of nothing but talking and listening is misleading even for those procedures that can be characterised in verbal terms. For it obscures the fact that we *do things with words*, to borrow Austin's (1962) memorable phrase, and in particular, that through words, we can perform therapeutic actions. In general, uttering words, one kind of action, is often a way of performing another kind of action. In a therapeutic context, it is particularly relevant that what you say to someone can be a way of *empathising* with them, *challenging* them, *(re)parenting* them, *educating* them, *coaching* them, *instructing* them, *expressing emotion*, etc. The therapist makes use of verbal exchange to perform therapeutic actions. With an understanding of psychotherapy where it includes the helping of people with their psychological problems, it makes sense to understand actions such as those mentioned above as being *therapeutic* actions.

So, it is a caricature to represent psychotherapeutic treatment as if it uses *mere* verbal exchange. It is not *mere* verbal exchange that matters, but verbal exchange insofar as that is a means to therapeutic action.

Going beyond Szasz' ideas, let's end this section with a different kind of objection to what I've argued: let's admit that the interventions we considered above *are* genuine treatments. But note that if we understand 'treatment' broadly enough, we can hold that they are pathocentric after all. For they are treatments which function to prevent the onset of psychopathological problems, or the transformation of non-pathological into psychopathological conditions (e.g., ordinary grief to prolonged grief). We can thus understand the interventions discussed above

as *preventative* interventions on psychopathological problems, and thus as conforming to the pathocentric model of psychotherapeutic intervention, so long as we have a more nuanced understanding of this model, and accept that 'treatment' can indicate prevention as well as cure.

In response to this, I agree that such interventions are preventative, and that insofar as they prevent psychopathology, they are pathocentric preventative treatments. But is that *all* they are? This does not seem plausible. They are *also* treatments of here-and-now, non-pathological conditions. This aspect of their status as treatments has nothing to do with potential psychopathology. Consider again Erskine's treatment of Ruth's non-pathological grief. Suppose we agree that what Erskine did constituted a preventative intervention, blocking potential prolonged grief. It *also* helped to relieve the non-pathological distress that Ruth presented with. So, as well as being a preventative intervention, it is also an occurrent intervention: a remedial or ameliorative treatment of Ruth's non-pathological grief, which has its status as treatment quite independently of any potential psychopathology.

5. The Nature of Psychotherapy

In §(2) I reconstructed Szasz' argument to highlight his fundamental concern: psychotherapeutic intervention. With a pathocentric model of that in place, and the myth of mental illness, the argument primarily supports: (MoP1) that there is no such thing as psychotherapeutic intervention. And from this we can derive: (MoP2) that there is no such thing as psychotherapy as a practice. But since I've argued that we should reject the pathocentric model of psychotherapeutic intervention, we should reject Szasz' argument altogether.

My primary focus has been on the pathocentric model of psychotherapeutic *intervention*, but we can now note that the pathocentric model of psychotherapy as a *practice* is equally dubious.

For such practice, as we've encountered it here, is *not* simply about treating psychopathology, but often focused on non-pathocentric topics, with treatment implemented through non-pathocentric interventions. And so, a defender of Szasz cannot plausibly concede that (MoP1) is unsupported, yet attempt to support just (MoP2) by means of the pathocentric model of psychotherapeutic practice instead.

Though the stimulus for my discussion has been Szasz' radical scepticism about psychotherapy, the substantive issue is the nature of psychotherapy. At a general level, I've highlighted that there is an important non-pathocentric dimension to psychotherapy. More specifically, various psychotherapeutic interventions in various modalities are non-pathocentric in that they are focused on non-pathological problems.

In philosophy, discussion of psychotherapy often happens either in the philosophy of psychiatry, or the philosophy of psychoanalysis. But the preceding discussion pertains to psychotherapy whether or not it is associated with psychiatry or psychoanalysis. It should thus be seen as belonging to a distinct field, the philosophy of psychotherapy. Nonetheless, it does relate to wider discussion in the philosophy of psychiatry. For if any psychotherapeutic interventions in *psychiatry* are non-pathocentric, then it is not plausible to accept a general 'medical model' of psychiatry, according to which psychiatry is simply 'the branch of medicine devoted to the study and treatment of disorders in mental or psychological functions, which are also referred to as psychopathology' (Guze, 1992, p. 4).

Now, the claim that there is an important non-pathocentric dimension to psychotherapy will not come as news to psychotherapists who use the sorts of interventions in the sorts of contexts we've considered, nor to theorists who have reflected on them. But it is worth stressing. For it is not just Szaszian sceptics who will reject it. Those who disagree with Szasz in that they think that any therapy-worthy psychological problems are genuine psychopathological problems

would reject it too. And so there is a non-Szazian objection to what I've claimed, namely: since problems such as grief are genuinely treated, they are psycho*pathological* problems.

What I've argued allows us to reject both of these perspectives. Of the interventions we have considered we should not say: "they are not focused on psychopathology, and so they are not psychotherapeutic", as the Szaszian does – this risks unjustifiably limiting the scope of the therapeutic. But *nor* should we say: "they are therapeutic, and so they are focused on psychopathology", as the non-Szasian opponent does – for this risks pathologising or medicalising ordinary problems in living, flying in the face of both intuitive and clinical classifications. Acknowledging the possibility of non-pathocentric psychotherapy in the specific way I've spelled out steers a course between these two unattractive options.

To end, I'd like to highlight some avenues for future work based on this, both theoretical and practical.

First, theoretical. There are several different but consistent strategies that should be explored together in developing the general idea of non-pathocentric psychotherapy. My strategy has been *topic*-centric: focusing on psychotherapy that has a non-pathocentric subject-matter. But this is perfectly consistent with a modality-centric approach. And it is consistent with other approaches. For instance, approaches which highlight the role of *formulation* in psychotherapy, especially where that is understood as an alternative to diagnosis. Here the emphasis is not on a clinician diagnosing some disorder but on therapist and service user co-creating a narrative about the person's difficulties, as the basis for an 'intervention plan tailored to the individual and their needs' (Johnstone, 2018, p. 32).

Furthermore, we should not assume that a topic-centric approach is necessarily a *problem*-centric approach. For psychotherapy can be non-pathocentric insofar as its subject-matter is

something non-pathological, yet not a *problem.* To spell this out, consider the definition of psychotherapy found in Wampold and Imel's *The Great Psychotherapy Debate*:

> Psychotherapy is primarily interpersonal treatment that is a) based on psychological principles; b) involves a trained therapist and a client who is seeking help for a mental disorder, problem, or complaint; c) is intended by the therapist to be remedial for the client disorder, problem, or complaint; and d) is adapted or individualised for the particular client and his or her disorder, problem, or complaint (p. 37).

Wampold and Imel claim that their definition is 'not controversial' (ibid), for it is consistent with different ways of thinking about psychotherapy and its effectiveness. Laudably, it doesn't restrict psychotherapy to the treatment of psychopathology, it includes problems and complaints too. But despite this level of agreement, I don't think that someone who wants to emphasise non-pathocentric psychotherapy should accept this as a *definition* of psychotherapy. For the definition restricts psychotherapy to some *problem* of the client's (pathological or otherwise), and *remedial treatment*. But we should not think of psychotherapy as so restricted.

Such a restriction neglects, for instance, *positive psychotherapy*, aligned with the positive psychology movement, which highlights how 'a partnership between client and therapist in which the building of positive resources should get every bit as much attention as the amelioration of symptoms' (Rashid and Seligman, 2019, p. 482). Psychotherapy, as well as addressing a client's problems, can have amongst its goals positive things like flourishing and happiness. We cannot accommodate this if we *define* psychotherapy as a matter of addressing problems.[8]

Relatedly, there are a range of matters that one might bring to – or that might emerge in – psychotherapy which are not problems, and which might be the sole focus of psychotherapy.

For instance, achieving a greater understanding of oneself, one's experiences, and one's history. Here, one seeks self-discovery, not the remedy of a problem – medical or otherwise.

Does this stretch the meaning of 'therapy' too far? There are *other* means of helping someone in self-discovery we wouldn't necessarily call *therapeutic*, for instance teaching and friendship – though even here the lines are blurry. But when a practitioner is aiding someone in their exploration of deeply personal matters of self, in a mode that is skilful, psychologically oriented, theory-based, supportive, and nurturing, it is far from clear why we would not regard this as genuine therapy. Indeed, approaches which emphasise that psychotherapy can be a form of 'moral praxis' accord with this, for they emphasise how therapy can be so much more than the technical, mechanistic production of some outcome (such as symptom relief). It can instead be a form of practical moral engagement which 'speaks to and creates changes in' a client's perspective on what constitutes a good life (Smith, 2009, p. 39).

So, there is much to explore in the general idea of non-pathocentric psychotherapy: there are approaches other than the topic-centric approach, and topic-centric approaches other than the specific one I've adopted. Developing the general idea of non-pathocentric psychotherapy should involve not only developing new approaches, but co-opting and organising existing approaches.

Finally, what might the *practical value* of such work be? I want to end with three suggestions. First, survey studies provide 'evidence implying that many psychologists and counsellors are interested in diagnostic alternatives [to the DSM and ICD] suitable for psychotherapy' (J. D. Raskin, 2019, p. 369, and see J. D. Raskin and Gayle, 2016 and Gayle and Raskin, 2017). The results reflect 'an uneasy relationship between psychotherapists and the... *DSM* diagnostic system that they regularly use' (p. 369). The kind of alternative sought must, unlike the DSM (and the ICD), be suitable for psychotherapists 'who do not see their primary role as diagnosing

and treating diseases, but instead as understanding and remediating psychosocially embedded problems in living' (p. 370).

Raskin's studies suggest that practitioners are hankering after an alternative that accommodates non-pathological problems in living. Developing our understanding of non-pathocentric psychotherapy, and the concerns it relates to, could be part of the philosophical foundations of such an alternative. This, in turn, could have further practical implications: therapists who want to claim payment from certain health insurance companies in the US need to report their work in terms of a *DSM/ICD* codes. A less pathocentric alternative to the *DCM/ICD* would have to involve reform to this system, thus a fuller understanding of non-pathocentric psychotherapy is relevant to the shape of such reforms. (Rubin, 2018 proposes such an alternative. See Cooper, 2019 for a response.)

Consider now the UK counselling and psychotherapy profession. The Scope of Practice and Education (SCoPEd) framework (https://www.bacp.co.uk/scoped) is a standards framework shared by bodies representing over 75,000 practitioners. The framework sets out core competences for training and practice, and aims to provide clarity on what psychotherapists do, to support service users in making informed choices.

The framework is organised around various themes one of which is *assessment*: 'assessing the needs of diverse clients or patients within a clear framework for understanding psychological distress, which takes account of risk and the need to work within personal limits' (p. 18). Currently, this aspect of the framework uses the broad term 'psychological distress', and in the first required competence talks of assessing 'the client's or patient's problems and suitability for therapy being offered' (p. 18). This language is *consistent* with non-pathocentric understandings, but doesn't explicitly demand them. On the other hand, pathocentric dimensions of psychotherapy are *explicit* in the framework: there is explicit talk of 'clinical

assessment', 'clients or patients with chronic and enduring mental health conditions' and 'diagnosis, psychopathology and mental disorders' (p. 18), etc. A modest suggestion, then, is that the framework could be improved by including *explicit* references to the non-pathocentric in the assessment section. A richer understanding of non-pathocentric psychotherapy could inform such a revision, and/or the framework's implementation in practice.

Finally, consider the emergence of the mental health service user movement. As Thomas and Bracken, 2004 helpfully summarise

> Service user groups are heterogeneous. Some are happy to accept the idea that they suffer from illnesses such as schizophrenia or affective disorders; they accept the language of psychiatry. Others reject the notion of mental illness completely, and are incensed that they might be forced to take medication and have their liberty taken away because their distress is interpreted in terms of illness; these people reject the language of psychiatry. Other groups lie somewhere between these extremes. Despite their differences, they share a common belief in their right to interpret their experiences in their own way, and to receive help accordingly (p. 361).

Given this, developing a richer understanding of the non-pathocentric dimensions of psychotherapy may be useful to those who resist mental health services (rejecting their emphasis on pathology), to service users who entirely reject a pathocentric understanding of their distress and means of receiving help, and to service users who don't reject such an understanding, but see it as incapable of capturing the whole picture. Consistently with the ethos of the user movement, developing a richer understanding of non-pathocentric dimensions of psychotherapy is best attempted in a co-creative way, *with* service resisters and users.

REFERENCES

Austin, J. L. (1962). *How to do things with words.* Oxford: Clarendon Press.

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. New York: Harper & Row.

Beck, A. T., & Weishaar, M. E. (2019). Cognitive therapy. In D. Wedding & R. J. Corsini (Eds.), *Current psychotherapies* (Chap. 7, pp. 237–272). Boston, MA: Cengage.

Bracken, P., & Thomas, P. (2010). From Szasz to Foucault: On the role of critical psychiatry. *Philosophy, Psychiatry, and Psychology*, *17*(3), 219–228.

Campbell, L. (2013). *Historical linguistics: An introduction*. Edinburgh: Edinburgh University Press.

Cooper, R. (2002). Disease. *Studies in History and Philosophy of Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences*, *33*(2), 263–282.

Cooper, R. (2019). Commentary on Jonathan Raskin's "What might an alternative to the DSM suitable for psychotherapists look like?" *Journal of Humanistic Psychology*, *59*(3), 376–384.

Cozolino, L. (2017). *The neuroscience of psychotherapy: Healing the social brain, 3rd ed.* New York: W W Norton & Co.

Cutler, J. (2014). *Psychiatry* (3rd ed.). Oxford: Oxford University Press.

Erskine, R. G. (2014). What do you say before you say good-bye? the psychotherapy of grief. *Transactional Analysis Journal*, *44*(4), 279–290.

Frances, A. (2013). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma, and the medicalization of ordinary life.* New York: William Morrow & Co.

Gayle, M. C., & Raskin, J. D. (2017). DSM-5: Do counselors really want an alternative? *Journal of Humanistic Psychology*, *57*(6), 650–666.

Guze, S. (1992). *Why psychiatry is a branch of medicine*. Oxford: Oxford University Press.

Haldipur, C., Knoll, J. L., & v.d. Luft, E. (Eds.). (2019). *Thomas Szasz: An appraisal of his legacy*.

Hayes, S. C., & Hofmann, S. G. (2017). The third wave of cognitive behavioral therapy and the rise of process-based care. *World Psychiatry*, *16*(3), 245– 246.

Johnstone, L. (2018). Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology*, *58*(1), 30–46.

Marwick, K. (2019). *Crash course psychiatry* (5th ed.). Elsevier.

Meichsner, F., Schinköthe, D., & Wilz, G. (2016). Managing loss and change: Grief interventions for dementia caregivers in a CBT-based trial. *American Journal of Alzheimer's Disease & Other Dementias*, *31*(3), 231–240.

Meichsner, F., & Wilz, G. (2018). Dementia caregivers' coping with pre-death grief: Effects of a cbt-based intervention. *Aging Ment Health*, *22*(2), 218– 225.

Neimeyer, R. A. (2012). Chair work. In R. A. Neimeyer (Ed.), *Techniques of grief therapy: Creative practices for counseling the bereaved* (Chap. 69, pp. 266– 273).

Neimeyer, R. A. (Ed.). (2016). *Techniques of grief therapy: Assessment and intervention.* New York: Routledge.

Neimeyer, R. A. (Ed.). (2021). *New techniques of grief therapy: Bereavement and beyond*. New York: Routledge.

Perls, F. (1973). *The gestalt approach & eye witness to therapy*. Oxford: Science & Behavior Books.

Pickard, H. (2009). Mental illness is indeed a myth. In M. Broome & L. Bortolotti (Eds.), *Psychiatry as cognitive neuroscience*. Oxford: Oxford University Press.

Rando, T. A. (Ed.). (1986). *Loss and anticipatory grief*. Lexington, Mass: Lexington Books.

Rashid, T., & Seligman, M. (2019). Positive psychotherapy. In D. Wedding & R. J. Corsini (Eds.), *Current psychotherapies* (Chap. 13, pp. 481–526). Boston, MA: Cengage.

Raskin, J. D., Maynard, D., & Gayle, M. C. (2022). Psychologist attitudes toward DSM-5 and its alternatives. *Professional Psychology: Research and Practice, 53*(6), 553–563

Raskin, J. D. (2019). What might an alternative to the DSM suitable for psychotherapists look like? *Journal of Humanistic Psychology*, *59*(3), 368–375.

Raskin, J. D., & Gayle, M. C. (2016). DSM-5: Do psychologists really want an alternative? *Journal of Humanistic Psychology*, *56*(5), 439–456.

Raskin, N. J., Rogers, C. R., & Witty, M. C. (2019). Client-centred therapies. In D. Wedding & R. J. Corsini (Eds.), *Current psychotherapies*. Boston, MA: Cengage.

Ratcliffe, M. (2017). Empathy without simulation. In M. Summa, T. Fuchs, & L. Vanzago (Eds.), *Imagination and social perspectives* (pp. 199–220). London: Routledge.

Ratcliffe, M. (2023). *Grief worlds: A study of emotional experience*. Cambridge, MA: MIT Press.

Rubin, J. (2018). The classification and statistical manual of mental health concerns: A proposed practical scientific alternative to the DSM and ICD. *Journal of Humanistic Psychology*, *58*(1), 93–114.

Sanders, P. (2018). Principled and strategic opposition to the medicalisation of distress. In S. Joseph (Ed.), *The handbook of person-centred therapy and mental health: Theory, research and practice*. Ross-on-Wye, UK: PCCS Books.

Smith, K. R. (2009). Psychotherapy as applied science or moral praxis: The limitations of empirically supported treatment. *Journal of Theoretical and Philosophical Psychology, 29*(1), 34–46

Szasz, T. (1960). The myth of mental illness. *American Psychologist*, *15*(2), 113–118.

Szasz, T. (1965). *The ethics of psychoanalysis: The theory and method of autonomous psychotherapy*. New York: MacMillan.

Szasz, T. (1974). The myth of psychotherapy. *Psychotherapy and Psychosomatics*, *24*(4/6), 212–221.

Szasz, T. (1988). *The myth of psychotherapy: Mental healing as religion, rhetoric, and repression*. New York: Syracuse University Press.

Thomas, P., & Bracken, P. (2004). Critical psychiatry in practice. *Advances in Psychiatric Treatment*, *10*(5), 361–370.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd). Hove, East Sussex: Routledge.

Wilkinson, S. (2022). *Philosophy of psychiatry: A contemporary introduction*. London: Routledge.

Worden, J. W. (2018). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (5th ed.). New York: Springer Publishing Company.

[1] For recent criticism see Haldipur, Knoll, and v.d. Luft, 2019, for a recent defence see Pickard, 2009, and for discussion of Szasz' view in the wider contexts of anti-psychiatry and critical psychiatry, see Bracken and Thomas, 2010.

[2] However, Sanders notes, some person-centred therapists 'simply accept the primacy of the medical model, and either renounce or 'work around' their person-centred principles' (p. 33). And N. J. Raskin, Rogers, and Witty, 2019, p. 131 highlight several examples of person-centred therapy focused on psychopathology.

[3] As Beck and Weishaar, 2019, p. 257 note, CBT was originally developed for major psychiatric conditions (e.g., Beck, 1967). But CBT is not *limited* to these. Hayes and Hofmann, 2017, p. 245 note that in third-wave CBT 'human psychological prosperity and the thriving of whole persons, not merely psychopathology' becomes more central.

[4] For instance, Frances (2013) argues that the DSM-5 is guilty of over-pathologisation meaning that 'mental disorder' applies to many more people and conditions than it should. One problematic consequence of this, Frances thinks, is that people in *genuine* need of psychiatric care get missed. See Raskin et al (2022) for a discussion of alternatives to DSM-5 and the ICD in psychology.

[5] From this description it seems that the way Erskine relates to Ruth has the hallmarks of empathy, as understood in the phenomenological tradition: for Erskine relates to Ruth in a distinctive second-person way which involves focusing on *her* and *her experience*. For nuanced discussion of empathy and second-person relating, see Ratcliffe, 2017.

[6] There are other conceptions of pathological forms of grief that these cases don't fit either (e.g., 'complicated grief' and 'traumatic grief'). For a rich philosophical discussion of different conceptions of so-called pathological grief see Ratcliffe, 2023, pp. 203–212. On psychotherapy for pathological forms of grief, see Neimeyer, 2016, 2021.

[7] Szasz, 1974, p. 216 claimed that the "autonomous psychotherapy" he practiced recasts the psychotherapeutic enterprise in a 'nonmedical, nondiagnostic, and nontherapeutic framework and vocabulary', and that he uses 'such words as "patient," "therapist,", and "treatment" as a matter of convenience...' yet eschews 'their medical, psychopathological, and therapeutic connotations' (Szasz, 1965, p. 11).

[8] This is not to say that positive psychotherapy cannot also be applied where there is a problem-centric focus – it can, and indeed, Rashid and Seligman's case example (pp. 517-519) involves someone suffering significant symptoms of depression. The point is that it is *also* applicable beyond such contexts, and that it can have goals beyond addressing problems.