

'Illness'

... and Its Human Values

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La psichiatria odierna è una branca medica e il proprio modello di riferimento è un modello medico; la definizione di malattia mentale attraverso questo modello, ma esso si rileva insufficiente quando si esplorano i campi di interazione dell'uomo con il suo ambito esterno: il sociale, il politico, l'etico.

Ciò ha determinato il sorgere di idee critiche verso la psichiatria medica: Szasz, Leifer, Goffman, Laing e Schieff accettano l'idea della scienza naturale relativamente alla malattia fisica, ma trovano inappropriato esplorare la psicologia umana. Nel "the myth of mental illness" Thomas Szasz vede la malattia mentale come angoscia del singolo in un mondo che socialmente emargina.

Un pensiero critico in modo differente è quello di Boorse: la nostra specie è la più evoluta in quanto a struttura e funzioni. Statisticamente il genere umano, incorpora variabili ma il valore medio di queste variabili non è rappresentabile con un valore medio tra tutti gli uomini, ma dalla variabile che genera la salute degli uomini: la variabile disturbo, invece, interferisce con il funzionamento naturale. La malattia è uno stato interno che può danneggiare la salute e le abilità funzionali e che può essere curata con terapie specifiche. Il malfunzionamento, lasciato privo di cure, è deleterio.

Boorse afferma che "c'è stato come un incidente sul termine storico di funzione biologica". La malattia mentale deve essere sufficientemente simile alle malattie fisiche per essere classificata con il nome di malattia e sufficientemente diversa per far sì che venga considerata in una categoria diagnostica con un diverso approccio clinico.

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Abstract

'Illness' has been largely defined by the medical profession, and 'mental illness' by psychiatry. Their main authority lies in the claim that their knowledge is objective and value-neutral. Thomas Szasz and other critics of the concept of 'mental illness' are not convinced by this claim and believe that psychiatry is a moral, not a medical discipline. They do, however, accept the natural science view of physical illness. The present paper outlines the medical model of illness and mental illness as presented by Christopher Boorse. Criticisms of the concept of 'mental illness' by Szasz are presented to suggest that the concept is a mistake. The notions of 'species design' and psychic malfunctioning are re-assessed. Arguments are offered to suggest that the concept of physical illness is also normative and not an objective account of reality as claimed by medicine. Ideas of existential philosophers are incorporated to show how medical science reflects specific values. In conclusion, the concept 'illness' is defined as a practically useful metaphor and 'mental illness' dismissed as a misleading concept.

We lock up people who gravely and harmfully trespass the limits of

understanding. We consider harmlessly insane those systems of interpretation which violate the bounds of good sense by consensus, the bounds which separate that which can be understood from that which cannot. Some things have meaning; some things do not. It is well not to confuse the categories.... You may plausibly chart types and meanings of schizophrenic doodle loops; but if you chart types and meanings of clouds and stones, they will come and carry you away. You will have regressed historically; you will have crossed the border, and committed yourself to the other side of the desk .

(Dillard, 1982:138-9)

Our understanding of illness has been shaped by medical science. Psychiatry is the result of applying this medical understanding to the psychological realm. 'Mental illness' is closely tied to our ideas of physical illness. But this extension of the term 'illness' to mental problems instigates virulent debate. The medical view sees itself as enlightened and rests upon a belief in scientific progress which will eventually 'cure' human suffering. Opposite views question the concept of mental illness, and see the true motives of psychiatry as social and political. They say 'mental illness' is a

form of deviant behaviour, and not an illness at all.

Within the medical framework, physical illness is assumed to be less controversial and more paradigmatic than 'mental illness'. Even critics of psychiatry (for example, Szasz, Leifer, Goffman, Laing, Scheff) accept the natural science view of physical illness and argue only that it is inappropriate to extrapolate it to human psychology. But by accepting this view of physical illness these critics of psychiatry actually reify the application of a 'natural science attitude' to human existence.

The following paper outlines the medical thinking which prevails about illness and presents some of the criticisms of the concept of 'mental illness'. The presumption of a 'species design', the question of mental malfunctioning, and the use of metaphor, turn out to be pivotal aspects of this assessment. I will then examine the claim to value-neutrality which underlies the medical model. This broad philosophical question leads to a more radical unveiling of the values implicit in applying the natural science concept 'illness' to human existence. Equating difference with pathology and conformity with health shows that medical science is not value-free.

Defining Illness and 'Mental Illness'

Illness and mental illness are defined in terms of the biological sciences underlying medical practice. The Medical Model is a natural science view of life. It is closely tied to ideas of biological functioning, which in turn are based upon the theory of evolution. As a result of evolution, humans have a 'species typical design' comprised of the interlocking functional systems supporting our life form;

On all but evolutionary time scales, biological designs have a massive constancy vigorously maintained by normalising selection. It is this short-term constancy on which the theory and practice of medicine relies ... Our species and others are in fact highly uniform in structure and function

(Boorse, 1977, p.557).

The structure of all organisms shows a means-end hierarchy with goal-directedness at every level. The goals that these various levels of functioning contribute towards are seen to be ultimately 'individual survival and reproduction'.

The species design is important for the medical model because it provides objective criteria for analysing disease. Statistical normality establishes the species design, incorporating natural variations according to sex, age, etc. However, statistically normal values 'represent, not the average person, but the average healthy person' (Boorse, 1977, p.546). It is the establishing of an ideal:

The idealisation is of course statistical ... Each detail of this composite portrait is statistically normal within the species, though the portrait may not exactly resemble any species member ... since any frog [for example] is bound to be atypical in some respect and to have suffered the ravages of injury or disease

(Boorse,1977, p.557).

Functions are derived from the 'species design' as the empirical ideal which allows for judgements about what is healthy for that species. Statements about functions will be value-free since what makes a causal contribution to a biological goal is an empirical matter (see Boorse, 1977, p.554-7).

Disease interferes with natural functioning and this can be detected empirically. It is therefore an objective and value-neutral concept; a matter of natural science, not evaluative decision. Disease is an internal state which falls within medical treatment and which impairs health so that at least one functional ability (survival or reproduction) is reduced to below typical efficiency for that individual (Boorse,1977, p.552). Functions are beneficial to their bearers while malfunctions are deleterious (see Boorse,1976b for further elaboration).

Boorse distinguishes 'disease' from 'illness'. He says that a disease becomes an illness if it is incapacitating and therefore,

1) undesirable for its bearer; 2) a title to special treatment, and 3) a valid excuse for normally criticisable behaviour

(Boorse,1975, p.61,and 1976, p.63).

Malfunctions of the internal physiological machinery constitute disease, and being ill 'involves having a disease serious enough to be somewhat incapacitating, which therefore supports normative judgments about treatment and responsibility' (Boorse,1977, p.552). Therefore, the concept of illness is embedded within the concept of disease, a person can be diseased and not ill but if illness is present so is disease¹.

According to Boorse, 'It is something of an historical accident that the term "biological function" calls to mind sex and excretion rather than intelligence and drive ...' (Boorse,1976, p.64). According to this view, the functional idea of health in physical medicine applies as straightforwardly to the mind as to the body; 'If certain types of mental processes perform standard functions in human behaviour, it is hard to see any obstacle in calling unnatural obstructions of these functions mental diseases, exactly as in the physiological case' (Boorse,1976, p.64). For there to be mental functions, some mental processes must play a causal role in actions in a sufficiently species-uniform way to call them 'natural'.

¹Boorse's distinction between disease and illness is not widely held (see Svensson,1995) and will not impact upon our discussion here.

Boorse points out one disanalogy between the physical and the mental case. Human mentality is more plastic than physiology and therefore we expect normal psychological functions to be less specific than their biological counterparts. Yet perceptual processing, intelligence, memory, 'drives', anxiety, pain, language, etc. serve 'standard functional roles throughout the species' (Boorse,1976, p.63).

An objective theory of mental health, like physical health, is meant to be a description of how we are constituted, not how we would like to be. It is this distinction which Boorse considers to be the value-free foundation of his model. Empirical inquiry will show if humans are 'by design' even-tempered, considerate, make love with 'dignity and decency' etc. (Boorse,1976, p.70). Boorse says,

However we may disvalue neurosis and seek to eradicate it, we cannot call it unhealthy until we know that the mind is not supposed to work that way. It is in no way obvious, and requires empirical support, that what clinicians see in their offices are usually cases of biological dysfunction

(Boorse,1976, p.71).

Boorse acknowledges that we have little knowledge of the relevant functional systems in psychological cases but that we can infer internal malfunction when the patient's biological behaviour (contributing to survival or reproduction) is 'incompetent'. For example, Rosenthal (c.f. Kendall,1975, p.311) concludes that fertility is reduced in at least four of the major types of mental disorders. Kendall (1975) reports many studies in which mental illness is often associated with a significantly increased risk of death. Boorse posits that many 'psychotics' and 'neurotics' are malfunctioning and thus pathological because their survival abilities are also decreased in more subtle ways,

Since opposite desires are common in human beings, there must be some normal mechanism for resolving them without permanent and paralysing conflict. If some of the neurotic's strongest desires remain locked in combat without freely releasing their motivational force in behaviour, it is not an implausible hypothesis that the conflict-resolution mechanism is functioning incorrectly

(Boorse,1976, p.76).

Although mental functions/malfunctions analogous to physiological functions/malfunctions have not yet been discerned to an extent that there is widespread agreement, Boorse considers psychoanalysis to be the best available model of mental functioning.

In arguing against these medical definitions of illness and mental illness, the following points will be argued: (1) the phenomena referred to by

'mental illness' do not have enough in common with physical illness to share the term 'illness', (2) the 'species design' is not an objective basis for medicine and psychiatry, (3) we do not have sufficient reason to believe that there is a mental equivalent to physical malfunction, and (4) the whole concept of illness itself is implicitly and intricately tied to specific human interests and values.

There cannot be 'Mental Illness'

'Mental illness' must be sufficiently similar to physical illnesses to qualify as 'illness' yet sufficiently different to justify a separate sub-category (Boorse, Macklin, Margolis accept this in arguing *for* a medical model, while Szasz, Flew, Leifer, accept it in arguing *against*). In *The Myth Of Mental Illness*, Thomas Szasz argues that genuine illness means suffering from a physical abnormality or malfunctioning of the body. Szasz makes a case that 'mental illness' is not similar to illness and these conditions are better thought of as 'problems in living'. The concept of illness was inappropriately extended to psychology and should remain concerned with physical conditions only.

It was Freud, Janet, Charcot among others who began to blur the distinction between illness and what just resembled illness in some ways. In this blurring, 'conditions' such as schizophrenia and hysteria were constructed and proclaimed 'illnesses'. This was achieved not through scientific discovery, but by altering the criteria whereby something qualified as a disease (Svensson, 1995, p.17). If a change in the concept of illness occurred to allow for the forming of the category 'mental illness', then the burden of justifying this change is on the psychiatric community which facilitated it². Arguments against extending the influence of medicine have been made, yet no sound argument in favour of this change

²Defenders of the Medical Model of 'Mental Illness' (for example Roth,1976, Taylor,1976, and Farrell,1979) claim that Szasz has misunderstood the way medical science progresses. They say all 'mental illnesses' may be based upon eventually discovered pathologies and the fact that their bases are not currently known does not exclude them from being considered diseases now. Pies and Roth (c.f. Svensson,1995,p.27) argue that schizophrenia was therefore a concept which developed according to the normal history of medicine and not indicative of a change in the concept of disease. But why hadn't the new diseases of schizophrenia and hysteria been long established as illnesses earlier, due to the suffering they caused? It seems that there had to be some shift in categorising illness that allowed debilitating conditions such as schizophrenia to become 'discovered' as diseases without any organic causes to be known (or perhaps even suspected?).

is forthcoming³. Justifications after a *fait accompli* do not constitute valid arguments in favour of it.

Mental and physical illnesses differ in their manifestations. Bodily disturbance is evident in signs like fever, pain, physical symptoms. Mental signs of illness, however, 'require that a person's beliefs and ways of looking at things are matched against those of the assessor or of the society they exist in' (Svensson,1995, p.18). In this case symptoms are not tied to a genetic or anatomical context, as with bodily symptoms, but rather to an ethical and social one (as Szasz's argument goes). To argue that mental illness has as objective a basis as physical illness supposedly has, is to suggest that society is somehow an objective criteria to judge a person against - that society is as 'natural' as the ideal functioning body.

According to Szasz (c.f. Svensson,1995, p.22), the label 'mental illness' deals with deviations from the norm only in one direction; towards immoral or illegal behaviour, not towards equal deviations in the law-abiding direction. It is a prescriptive term disguised as a descriptive one. It presents deviations from social, not species, design. Boorse could counter that Szasz is not criticising the concept 'mental illness' but only the bad practice of psychiatrists ignorant of their own model. To argue that the actual medical model of mental illness is based upon social norms rather than objective science, it is necessary to show that the species design is a reflection of values, not just facts.

Values in the 'Species-Design'

In Boorse's model we take the 'species design' from statistics of healthy normals, not from an unbiased representation of the population of a species as a whole. We pre-omit certain 'conditions' before even establishing our "objective" criteria for omission. For example, to ascertain 'normal' blood sugar we omit individuals who have diabetes - our judgements about deviation are from the ideal, not the norm. But who established the ideal, and how without appealing to preconceived values? The philosopher Lester B. King says that in applying statistical methods we '... already have in mind the idea of health. We exert selection on the cases we study' (King,1954, p.195-6). In Agreement with Szasz, King sees 'health' and 'disease' as value judgements based upon something more than just conformity to a statistical species-design.

The species design is said to be 'highly uniform' and yet every individual will deviate from this ideal. We expect enough similarity that medicine can

³A related question to be answered by defenders of the medical model is why we should emphasise the apparent similarities between physical and psychological 'illnesses' rather than their numerous and fundamental differences.

compare our individual functioning to our species ideal functioning and yet at the same time we expect no one will fit the whole design. It is a model in which health is theoretical conformity to an ideal which has no ontological existence⁴. 'The intuition behind our account of health and disease will be a simple one ... It is that the normal is the natural' (Boorse,1977, p.554). Normality is what is natural, yet it would be unnatural for any of us to be completely 'normal'. It seems obvious that wider diversity, recognised in its exclusion from the species design, is what exists 'naturally'.

Boorse assumes that a wide range of diversity in design and function is somehow not natural or normal. He starts out with the presupposition that there must be a narrow range of 'normal', which he then "discovers" by selecting out deviance. This judgement claims to give an 'objective' basis for specifying disease/illness. This may be necessary to establish medical practice, but by not acknowledging his practical interests Boorse confuses medical inventions with actual discoveries; the necessary methods of science with the reality of nature itself.

Practical interests bring instrumental knowledge. Boorse takes functions to be essentially practical rather than aesthetic, spiritual etc. They contribute towards biological goals like survival etc. but who decided that survival is the 'objective' goal of our species? Function statements may be empirical only after we have decided what sort of function and which goals we will value. These are interesting decisions, not empirical facts. For humans there is choice in regard to whether we aim to merely exist, to live by conforming, or to live 'well' (however we interpret that). Function statements add a value to mere causal events. Boorse says,

Our conception of disease required no value judgement about what forms of human life are admirable or desirable

(Boorse,1977, p.571)

... we must avoid confusing empirical questions with deep normative issues about the goals of human life and the role of health professionals in achieving them

(ibid, p.572).

⁴This is similar to cognitive prototypes in a prototype theory of stereotypes in which the prototypical Canadian, for example, does not actually exist but forms a 'best guess' about what any one Canadian would be like. We wouldn't expect any individual Canadian to fit the whole prototype. However, in the medical model the species design 'prototype' is not a best guess about individuals in that species, but a skewed prototype, a pre-selected ideal of what each individual should be. It is prescriptive, not descriptive, and does not answer how we decide who is sub-functional and thus precluded from the statistical sample.

'Disease' is an interpretation that reveals underlying practical interests and biological values. The species design is a reflection of social norms rather than bare perception of the state of nature. By denying the values implicit in his empirical method and in the disease framework itself, Boorse has confused normative with objective. And Szasz is sustained in his claim that mental illness is a moral category, more a value judgement than a medical diagnosis.

Also, the species design is said to be abstracted from reference classes smaller than the entire species-class, for example classes of similar race, sex, age etc. which may have functional variations. But how do we decide when we are looking at a sub-class rather than a malfunction? How do we decide which groups constitute a legitimate sub-class for design comparisons? Could families with one schizophrenic member constitute a class? If so, features which we consider malfunctions could actually be functions of this sub-species design - unless these functions or the class itself were pre-judged as subnormal. But again we are faced with a normative judgement sneaking beneath the supposed objective criteria. It seems that the species design must at some level presuppose currently accepted values as 'natural' in order to claim objectivity. And this, of course, is not objective at all.

Medical science fosters the mistaken assumption that all human behaviour can be objectively organised into normal and abnormal. Laurence Simon (1994) suggests that human brains may be as different from one another as human faces. These innate differences may cause individual differences in how we adapt. These abilities are enhanced or deprived by our environment and relationships. As the individual develops he/she becomes increasingly capable of creating differences in their outlook and coming to new conclusions about the world based upon these reflections. Human consciousness seems to be infinitely self-regulating and we have no idea how this is accomplished. Szasz agrees that 'problems in living' are not due to biological malfunctioning but due to social adaptation - the purposes that the human being is made to serve:

In cases where difficulties of social adjustment are not caused by malfunctionings of the human body, we should, [Szasz] suggests, not interpret the problems in medical terms, but rather in legal, political, ethical, social etc. terms, and we should also not call those problems illnesses

(Svensson,1995, pp.52-3).

Szasz argues that the re-definition of illness from histopathology (abnormal body state) to psychopathology (abnormal personal behaviour) is unjustified. The medical model claim to objectivity based upon the species design seems dubious. Now Simon and Szasz are suggesting that in

the mental realm 'malfunction' may not occur. If there is no mental malfunction, there can be no mental 'illness'.

Adaptation rather than Malfunction

In *What a Theory of Mental Health Should Be*, Boorse takes the Id, Ego, and Superego as psychic structures and assigns functions similar to biology: motivation, rationalism, and socialisation. This gives Boorse a 'species design' for the mind, to which can objectively be applied sub-par functioning and thus mental disease;

Formally speaking, psychoanalytic theory is the best account of mental health we have. It closely follows the physiological model by positing three mental substructures, the id, ego, and superego, and assigning fixed functions to each ... it would not be difficult to construe psychoanalytic theory as a set of theses about biological functions of the mind

(Boorse, 1976a, p.78).

However, as we have seen, a species design is not objective - especially in relation to the mind which is much more elusive in terms of its function than body organs. The psychic realities which psychoanalysis tries to understand cannot be perceived directly but can only be hypothesized indirectly as being somewhere in the 'self'. They are therefore inaccessible to the methods of biological science. Psychoanalysis can provide an explanation of mental functioning which accounts for human behaviour, but not, according to the Swedish philosopher Tommy Svensson, in terms of malfunctioning:

When the mental structures contribute to the mental functional system as a whole, and ultimately to the behaviour of the individual, in a way that is unacceptable to the individual himself or to his social surroundings, this only means that the outcome of one or more of the functional systems is judged to be undesirable. The 'function itself' could not be viewed as out of order

(1995, p.96).

Svensson says that bodily organs have a natural order of functioning built into their very 'construction'. But, he believes, a mental functional system works according to how it was educated during the formative period when mental structures are 'flexible and shapable'. It will then function according to its acquired form, until the psychoanalyst appears to aid the individual by 're-education'⁵. He emphasises what Boorse has referred to as the

⁵This is a classical view of psychoanalysis which would not be shared by analysts like Fairbairn or Guntrip, who would argue that the individual

'plasticity' of the mental realm.

Svensson (pp.96-8) says that the way a child is treated can produce different "characters" like 'anal', 'oral' etc. and that these differences do not point to the lesser or greater degrees of functioning of one or other mental functioning system. They only point to different ways of functioning,

To speak of varying degrees of functioning we would have to match the character of the individual against some social standards, which would be culture-specific and relative to societal evaluation systems. Quite a different thing is that in some cases the mental structures of an individual could be 'shaped' to produce extremely strange and highly irrational outcomes (beliefs, desires, experiences) which would have behavioural consequences of a dramatic nature. But this would not, this is my contention, point to a break-down of some 'natural' (in a biological sense) order of functioning. It would just point to a very different way of functioning, and one which would undoubtedly in many cases call for intervention. The point, however, is that the unusual function would not be a disease in the sense that is the case with a cancerous lung that gradually is stopping performing its biologically definable function

(1995, p.97-8).

So the plasticity of mental functioning leads to the shapable quality of human behaviour. We can never establish objective criteria for judging behaviour as 'ill' or functioning as 'malfunctioning', because mind does not have the intransigent quality of body.

Laurence Simon (1994) views psychoanalysis as an inappropriate metaphor or paradigm because it shares the basic assumptions of medicine. He considers analysts employing notions of mental illness as equivalent to patients employing defence mechanisms or other distortions of reality (Simon,1994, p.7-8). Every individual, according to Simon, acts as a scientist employing a personal paradigm of the world. We confront anomalies and either alter our paradigm or defend ourselves against the disconfirming evidence. Groups will have dominant consensual paradigms as well as paradigms which are judged to be ineffective or less worthy, these '... might be attacked by religious groups as sinful, by civil community standards as criminal, by political evaluators as treasonous, or by the modern psychiatric establishment as mental illness' (Simon, 1994, p.12). What has been called 'mental illness' is simply a judgment by one person as to both the validity and the morality of the paradigm of another.

Natural science cannot describe what is basic to human functions of

has an 'organising principle' which guides their development - a sort of individual, not species design. If there is no mental malfunction, however, deviation from an individual design is also not mental disease.

consciousness and experiencing. A description of human functioning should begin with consciousness as the central and irreducible element in the psychology of human functioning (Simon,1994, p.76). Simon makes the point that neither Freud nor Skinner 'could utilise his own theory or that of the other to explain how each had created either psychoanalysis or radical behaviourism' (Simon,1994, p.76).

'Problems in living' are most parsimoniously explained as adaptation - as functional in the context of difficult living situations;

What are the "normal" human responses to the type of violence, sexual abuse, degradation, and debasement regularly discovered in the lives of our patients? Might not the therapists themselves reconstruct reality and make it more palatable if they had experiences similar to those of their patients? Although no two individuals deal with reality in the same exact way, we assume that certain realities produce commonalities in human response to them

(Simon,1994, p.85).

We function psychologically in relation to each situation we encounter in terms of our relationships in that situation. Our conscious experience of our world must be defined in these human terms, not just in terms of the biological criteria of survival and procreation. Consciousness evolved as our main tool of adaptation (Simon,1994, pp.91-6). It facilitates individual strategies and *choices*.

If an individual experiences a pain that they cannot justify and accept, they may turn to defence mechanisms as a solution. This can be seen as an adaptive and functional strategy to avoid unnecessary pain. This creates the impression for the individual of successful adaptation by altering conscious experience. As human beings we all alter reality, and affect it in our act of perception at least as much as we discover it. We have no experiential version of the world that can be considered definitive. Because different individuals have alternative ways of experiencing the world, '... a choice between [competing versions] cannot be made compelling in empirical or logical terms alone for the choice is between empirically and logically self-validating and self-sustaining systems (Pollner,1975, p.419). To judge a specific personal adaptive paradigm as 'mental disorder' is totally unscientific. The metaphor of 'paradigm' is more scientific than the metaphor of 'disorder'.

Simon argues that '... [psychotic] patterns of behaviour, especially the pattern of activity known as schizophrenia, are adaptive modes of experiencing and being in the world and as such represent a variety of personal adaptive paradigms' (Simon,1994, p.147). All we **really** know is that schizophrenia, for example, is a way of being in the world. To claim we know more is simple delusion. Odile Tomacek wrote to *The American*

Psychologist in 1990,

My schizophrenia makes me be in such a way as I can accept myself and it is not my fault if the rest of the world will have little to do with it ... I do not wish to be a so-called 'normal' individual at all

(c.f. Simon,1994, p.161).

A truly scientific response to schizophrenics would be to help them experience their 'disease' as an acceptable, though possibly burdensome, mode of living in the world - to assist in the removal of psychiatric (moral) judgements. By throwing off the notion of mental 'disorder' or 'illness', we also lose the myth of the 'well adjusted' or 'normal'. We begin by assuming that all human beings are as different as they are similar. The difference in attitude is described by Donald Campbell;

When an evolutionary biologist encounters some ludicrous and puzzling form of animal life he approaches it with a kind of awe, certain that behind the bizarre form lies a functional wisdom that he has yet to understand. I believe the case for sociocultural evolution is strong enough so that psychologists and other social scientists, when considering an apparently bizarre, incomprehensible feature of their own social tradition, or that of another culture should approach it with a similar awe, expecting that when eventually understood, when our theories have caught up with it, that seemingly bizarre superstition will turn out to make adaptive sense

(1975, p.1123).

The discussion thus far suggests an answer to whether there can be 'psychological or mental illnesses'. The 'species design' does not provide an objective criteria for mental illness. So psychiatry uses implicit value judgments, mistaking social for natural, consensus for reality. The plasticity of psychological functions means it is more parsimonious to think of mental adaptation than 'malfunctioning'. If mental life is characterised by adapting to idiosyncratic biographies, then the natural science method of induction; generalising about everyone from specific empirical findings, is inappropriate. If the medical model of physical illness is not analogous for human mental life, then using the same terms or metaphors for both realms is confusing and misleading.

Metaphors and the Use of Medical Terms

In physical diseases, malfunctioning is usually presumed to be due to structural abnormality (Svensson,1995, p.87-8). But in mental malfunctioning there could be no structural abnormality in the same sense of 'structural abnormality' since such abnormality would have to be based in biology, which would result in a somaticist view, therefore no 'mental' illness. If there is a mental type of structure, dissimilar to organic structure, which malfunctions, we have the misleading use of the same term 'structure' as first literal and then as metaphoric (it is *as if* the mind had a malfunctioning structure like a malfunctioning organic structure). The meaning we attach to words influences our thinking, our thinking becomes our practice, then in practice we forget our original thinking. Forgotten metaphor is a factor in the development of the category 'mental illness' (Szasz attributes this mainly to Freud)⁶.

By emphasising certain aspects of a phenomenon and discounting others, '... a metaphor is a powerful tool in making and remaking our ways of viewing and evaluating the phenomenon in question' (Svensson, 1995,p.126). It becomes our understanding. A mistake occurs when we '... lose sight of the metaphorical status of a word or designation. If we drop the "as-if" character of a certain way of speaking of a phenomenon, we are not merely re-allocating attitudes, but re-allocating facts' (Svensson,1995, p.126).

According to Sarbin, 'By recognising the metaphorical nature of "symptoms" and "illness" and the hypothetical nature of "mind", the mythical character of the mental concept is exposed' (1967, p.447). The medical model asserts that 'mental illness' is the result of a 'machine-fault' in the psychic apparatus. Here, "psychic apparatus" is metaphorical - it is *as if* the mind were a machine, which it is not. It does not exist in the same way as a material object. And if "psychic apparatus" is metaphorical, so are the mechanistic terms "mental functioning", and "malfunction".

'Machine-model' metaphors may be useful in relation to the body, but no one says the body *literally is* a machine. Extending the same metaphors to the mind is to imagine a machine within a machine. The terms are the same, yet 'mind' is not existent as an entity in at all the same way as 'gut', 'brain', etc. But we begin to think of mind as having similar properties to body (including malfunction). This machine within a machine seems to

⁶Champlin (1980,p.7) says 'Mental illness is no more a metaphor than is "mental age" "mental breakdown" ... '. But these are metaphors. It is *as if* the mind has broken or *as if* it has an age apart from the chronological age of the biological organism. These terms are not meant as literal descriptions of the facts, they are specific models for understanding phenomena.

give rise to mind-body dualism. This is a discredited notion within science, so a medical model will want to avoid it. A mental functional system will have to be correlated with physical phenomena, yet not reducible to it (or else mental illness becomes physical illness).

Boorse attempts to draw out a non-dualist yet non-somaticist line. To agree that every mental event is correlated with a physical event does not entail agreeing that every type of mental event is correlated with a type of physical event. 'If the mentalistic vocabulary is not neurologically definable, there will be no way to reduce causal laws of the mind to causal laws of the body' (see Boorse, 1976, pp.64-8). So according to Boorse, future empirical refinements could reduce mental disease to physical malfunctioning, and psychiatry to general medicine. But if these neurological developments occurred, they would only show that the process of psychological adaptation is carried out neurologically, not caused by neurology. The mental realm seems so malleable that the term function "functions differently" than in physiology, and "causal laws", if applicable, seem idiosyncratically enforced.

At this point it seems reasonable to conclude that it is not sensible to think of there being 'mental or psychological illnesses'. Some of the preceding discussion also impinges upon the question 'what is illness'. The question of 'species design' reveals implicit values and interests inherent in the concept of illness, and the appropriateness of remaining sceptical regarding the assumptions of medical 'knowledge'. There are also other broad philosophical issues woven through the definition of illness.

Philosophy and Illness

Discussing normal and abnormal becomes deeply intermingled with social, as opposed to biological, standards. Conformity to social values is not reasonably thought of as relevant to a model that wants to claim empirical objectivity. Inferring the condition of so-called 'mental illness' is not biologically based, as Boorse maintains, but socially determined. However, there is a sense in which physical illness is also socially constructed and not an objective transcription of natural reality.

Lester King and Peter Sedgwick both question the notion of disease as value-neutral, instead asserting that disease is historically and socially contingent. They agree with Habermas (1972) that facts and values are inseparable and that all knowledge is formed by the human interests of those constituting it. Our 'knowledge' of disease is invested with human values which influence our thinking on these matters. The concept of disease itself is particularly human; expressing our interest in survival and flourishing of the human race⁷. Disease is a peculiarly human way of

⁷The Norwegian philosopher Herman Tennessen points out that

looking at living functions, and to think disease entities exist apart from our thinking is to anthropomorphise life in a quite transparent way.

Are external disease entities real, or only ill people real? King, for example, says the reality is sick patients, the abstraction is the so-called disease (King,1954, p.201). A disease is a complex pattern constituting a class within a framework which usefully organises crude experience:

That pattern which we call a disease is subject to modification, recombination and subdivision of its elements, as our knowledge increases. What one epoch calls a disease is, to a latter period, only a symptom

(King,1954, p.202).

King says that diseases do not have an independent reality apart from the knowledge and recognition of the inquiring physician (ibid, pp.199-201). He says that material tangible things exist before we discover them. Diseases, however, are not things in the same sense as 'rocks, or trees, or rivers'. They are patterns or relationships, and in what sense does a pattern exist? King gives the example of the Ninth Symphony - did it exist somewhere waiting to be discovered, or did Beethoven create it out of non-existing? In the same sense, does a disease have a real existence or is it '... created by the inquiring intellect, carved out by the very process of classification, in the same way that a statue is carved out of a block of marble ...?' (ibid, p.200).

King reminds us that the point of departure for medicine is arbitrary, based upon practical considerations. It does not clearly represent nature itself, but only the nature of its task,

The individual and his surroundings form an integrated system which we can arbitrarily divide into two parts ... Medical science studies the reactions of the internal component and its relations with the external component. A separation is artificial, but none the less necessary for convenience and practicality

(King,1954, p.193).

King's point is that basic experience is unknowable and thus open to multiple interpretations. We create frameworks of interpretation, like the notion and classes of disease, and come to believe that our schema reproduces the conditions of the substrate:

As we, in our own experience, create one pattern after another, we wonder whether these match the patterns of reality. Sometimes we feel that we have constructed a reasonable approximation. Then we can

conforming to nature as an objective criteria is itself implying a value. This will be described later.

only wait and see how our proffered blueprint of organisation enables us to deal with future experience. Our difficulties arise only when we are arrogant in our assurance

(King, 1954, p.203).

This scepticism about what we know contrasts sharply with the brash certainty of medical science as it is practiced in hospitals across the country. Boorse maintains that disease and illness are based upon certain objective deviations from a 'natural' species design which defines what is 'normal'. This whole framework is questionable - how objective is the species design, and what is the ontological status of the patterns we call 'disease'?

Sedgwick reinforces King's argument. According to his view, there are no illnesses or diseases in nature. It takes a human observer to discriminate illness from other sources of pain or enfeeblement:

Out of anthropocentric self-interest, we have chosen to consider as 'illness' or 'diseases' those natural circumstances which precipitate the death (or failure to function according to certain values) of a limited number of biological species: ourselves, our pets and other cherished livestock, and the plant varieties we cultivate for gain or pleasure'

(Sedgwick,1982, p.31).

Sedgwick sees all sickness as deviancy from a more desirable state of affairs. The presence of a particular state is attributed to 'illness' because of its comparison with some normative alternative state. Illness is not discovered, it is agreed. Szasz, Leifer, Goffman, and others mistakenly accept the 'natural-scientific, value-free language of physical medicine' but criticise heavily the socially and politically loaded language of psychiatry (Sedgwick,1982, pp.11-23). In fact their argument with psychiatry rests heavily upon comparing the "descriptive" anatomical and genetic context of physical illness with the interpretative social or ethical judgments of psychiatry.

Natural science assumes that facts and values can be separated and that the professional investigator is interested only in the facts. Therefore, the interactive relationship between the investigator and their facts is denied. The psychiatrist deals simply with processes that exist in the individual within an objective structure, which is prone to malfunction, and thus to corrective 'treatment'. Sedgwick believes '... the clinical positivism of 'psychopathology' [must] stand condemned for its stance of cultural smugness, its erection of a local twentieth century style of assessment into a timeless biological universal, its failure to take stock of its own social role' (Sedgwick,1982, p.26). He would apply this critique to physical

medicine as well. He says that rather than prescribe the natural sciences to psychopathology, it makes more sense to reveal '... the character of all illness and disease, health and treatment, as social constructions' (ibid, p.29).

Each culturally specific account of illness must involve a theory of the person, of the boundaries between the person and the world 'outside', and of the ways in which adverse influences can trespass over these limits and besiege or grip the individual. If the current theory of the person is positivistic and physical, the agencies of illness will be seen as arising from factors within (or at the boundaries of) the body; in cultures with an animistic tradition, the invasion will be one of the spirit or soul'

(Sedgwick,1982, p.35).

So 'Fever and madness, the broken limb or the broken spirit' are aspects of the same normative frame, situated inside one explanatory theory. All illness expresses a social value judgment and an attempt at explanation which guides us in our efforts at controlling the disvalued condition. The anti-psychiatrists got half-way there in asserting that psychopathology was really deviancy but missed the point that the logic of physical illness is the same.

There is a last crucial philosophical point to address to medical model theorists. Even if it were true that medical science had an objective basis in the species design, and mental illness made sense, there is still an implicit value judgment in this model. It assumes that what supports our continued biological survival is 'normal', 'natural', and thus an indication of what is functional. It is taken for granted that species and individual survival is the ultimate human goal. Not only is this a huge assumption, but it ignores another basic human aspect of our existence. Our consciousness. With a highly developed consciousness, humans are uniquely capable of reflecting upon our existence, and making choices in relation to our living. And there may well be a conflict between our insight into our existence, and our survival as a species. In other words, our cognitive 'nature' may turn upon our physical 'nature' in a way that contradicts it. This is argued in two simple points by Herman Tennessen in 'Knowledge versus Survival':

(1) An overendowment with insight may prove biologically fatal to man; (2) Obsession with biological survival may hamper man's ability to perfect a true understanding of himself and his world

(Tennessen, 1973, p.408).

The first point, extended by another Norwegian philosopher Peter Wessel Zapffe, argues that the human capacity for (existential) insight, when extrapolated beyond its biological efficacy, may yield horrifying and

unendurable insights into the absurdity of the totality of human existence. The second point is about how we can obtain reliable knowledge of anything since our view of the world has been based upon what has supported our survival till now, exemplified in our mistaking science for reality. Tennessen suggests that there is not 'a single sentence among what we today look upon as adequate transmitters of our most important, surest and most indisputably significant assertions, which will not, at another stage of insight's perfection, become an object of ridicule and painful shame' (1973, pp.409-10).

The world we know is determined by the knowing capacities we have developed for our survival. We have come to associate truth with those ideas which have enhanced or promoted our abilities to survive as a species. And an aspect of this survival bias in our thought is to circumvent the underlying assumption: What is so good about survival? To reflect upon life in a way that makes us question species or individual survival, or makes us not want to procreate, is by medical definition a sign of malfunctioning. If depression, for example, increases our ability to see through the camouflage of life to our existential condition, then one's values determine if we see depression as functional or as a malfunction. If we assume, with medical science, that survival is our goal, depression is an 'unnatural obstacle', a disease or illness. If we value insight, or "truth" no matter the consequences, depression is an accomplishment.

Medical science is too 'ego-involved' in our successful survival to claim that it is an unbiased description of what is. It denies the role of the spectator, or observer, who thereby mistakes their interests for reality. The "objectivity" of statistics, of a species-design, and the whole view of natural science rests on an unexamined common-sense attitude which equates 'natural' with desirable. Conformity to nature is health, divergence is pathology. To view the world from the interests of human survival colours what is seen, and does not question the value of surviving itself.

The human ability for insight, to stand out from our nature, and choose, reveals a concealed value in medical science;

It is thus "in the interests of the genes" to keep us alive, willing and capable of reproducing i.e. healthy and thriving, and happily taking our life for granted. Depression must be cured. No metaphysic-melancholic-clairvoyance can be permitted

(Tennessen,1982, p.11-2).

Survival of the species requires a certain ignorance on the part of the individual, who is being used as an expendable pawn in the scheme of things⁸. So we have "discovered" a 'species design' valuing mental

⁸This highlights the interesting point that there is a conflict between individual survival and species survival. While one is necessary for the

other to a point, the individual must also acquiesce to the whole breeding cycle, and personal extinction, without too much anxiety, if the species is to blindly continue.

References

- Albee, G. (1969). 'Emerging Concepts of Mental Illness and Models of Treatment: The Psychological Point of View', *American Journal of Psychiatry*, Vol.125: 875-91
- Boorse, C. (1975). 'On the distinction between disease and illness', *Phil. and Public Affairs*, Vol.5: 49-68
- Boorse, C. (1976a). 'What a Theory of Mental Health Should Be', *Journal for the Theory of Social Behaviour*, Vol.6: 61-84
- Boorse, C. (1976b). 'Wright On Functions', *Phil. Rev.*, Vol.85: 70-86
- Boorse, C. (1977). 'Health as a Theoretical Concept', *Phil. of Science*, Vol.44: 542-73
- Campbell, D. (1975). 'On the Conflicts Between Biological and Social Evolution and Between Psychology and Moral Tradition', *Am. Psychol.*, Vol.30: 1103-24
- Chamberlain, J. (1990). 'The Ex-Patients Movement: Where We've Been and Where We're Going', *Journal of Mind and Behaviour*, Vol.11: 323-36
- Champlin, T.S. (1980). 'The Reality of Mental Illness', *Philosophy*, Vol.56: 4-21
- Dillard, A. (1974). *Pilgrim at Tinker Creek*. New York: Bantam Books
- Dillard, A. (1982). *Living By Fiction*. New York: Harper Colophon Publications.
- Farrell, B.A. (1979). 'Mental Illness: A Conceptual Analysis', *Psychol. Med.*, Vol.9: 21-35
- Habermas, J. (1972). *Knowledge and Human Interests*. trans. Jeremy J. Shapiro. London: Heineman
- Kendell, R.E. (1975). 'The Concept of Disease and Its Implications for Psychiatry', *B. J. of Psychiatry*, Vol.127: 305-15
- King, L.B. (1954). 'What Is Disease?', *Philosophy of Science*, Vol.21: 193-203
- Mackin, S. (1996). *The Medical Model Defended*, *Lecture Notes* (Phil and Psych.)
- Macklin, R. (1973). 'The Medical Model in Psychoanalysis and Psychotherapy', *Comprehensive Psychiatry*, Vol.14: 49-69
- Nagel, Thomas (1974). 'What Is It Like To Be a Bat?', *Phil. Rev.*, Vol.83: 435-50
- Pollner, M. (1975). 'The Very Coinage of Your Brain: The Anatomy of

'happiness' as 'health', which may also require one to be existentially dull. To adjust to nature at the expense of human cognitive ability is a value. From the point of view of the existentialists, I would argue that it is no less than a question of 'human dignity'. From a medical model perspective, an existentialist may be considered a 'madman', a malfunctioning individual, choosing contrary to nature's values of survival, but he would only be mad in the sense of being open to seeing or understanding too much ...

Assessments of mental functioning and deviations from it (mental illness) must be decisions of the natural-objective kind (biological, statistical, non-evaluative) and not of the normative (social or evaluative) kind for the medical model of mental illness to be valid. We have seen that they are not. The more paradigmatic concept of physical 'illness' is likewise intricately tied to human values. Illness is an interpretation based upon practical considerations of human survival. It is a practically useful metaphor for reality but too imbued with the value of survival to be taken as an objective description of what is.

*Either this world, my mother, is a monster, or I myself am a freak.
Consider the former: the world is a monster. Any three-year old can*

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- Reality Disjunctures', *Phil. Soc. Sci.*, Vol.5: 411-30
- Roth, M. (1976). 'Schizophrenia and the Theories of Thomas Szasz', *British Journal of Psychiatry*, Vol.129: 37-26
- Sarbin, T.R. (1967). 'On the Futility of the Proposition That Some People Be Labelled Mentally Ill', *Journal of Consulting Psychology*, Vol.31: 447-53
- Sedgwick, P. (1982). *PsychoPolitics*. London: Pluto Press Ltd.
- Simon, L. (1994). *Psycho"Therapy": Theory, Practice, Modern and Post-Modern Influences*. Westport CT.: Preager Publ.
- Slater, E. (1975). 'The Psychiatrist in Search of a Science: The Depth Psychologies', *British Journal of Psychiatry*, Vol.126: 205-24
- Sorabji, R. (1964). 'Function', *Phil. Quarterly*, Vol.14: 289-302
- Svensson, T. (1995). *On the Notion of Mental Illness*. Aldershot, UK.: Avebury Books
- Szasz, T. (1972). *The Myth of Mental Illness*. St. Albans UK.: Paladin Publ. Ltd.
- Szasz, T. (1976). 'Schizophrenia: The Sacred Symbol of Psychiatry', *British Journal of Psychiatry*, Vol.19: 308-16
- Taylor, F. K. (1976) 'The Medical Model of the Disease Concept', *B. J. of Psychiatry*, Vol.128: 588-94
- Tennessen, H. (1973) 'Knowledge Versus Survival', *Inquiry*, Vol.16: 407-14
- Tennessen, H. (1982). 'Some Heterodox Variations on a Familiar Theme by Wittgenstein', *Manuscript Copy* (Publ. details unknown): 1-13
- Wright, Larry (1973) 'Functions', *Phil. Rev.*, Vol.82: 139-68

see how unsatisfactory and clumsy is the whole business of reproducing and dying by the billions. We have not yet encountered any god who is as merciful as a man who flicks a beetle over on its feet. There is not a people in the world who behaves as badly as praying mantises. But wait, you say, there is no right and wrong in nature; right and wrong is a human concept. Precisely: we are moral creatures, then, in an amoral world. The universe that suckled us is a monster that does not care if we live or die - does not care if it itself grinds to a halt. It is fixed and blind, a robot programmed to kill. We are free and seeing; we can only try to outwit it at every turn to save our skins ... or perhaps we are the freaks, the world is fine, and lets us all go have lobotomies to restore us to a natural state. We can leave the library then, go back to the creek lobotomised, and live on its banks as untroubled as any muskrat or reed. You first.

from *Pilgrim at Tinker Creek*, Annie Dillard (pp.180-2)

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Notes