

ABSTRACT

ILLNESS AND MENTAL ILLNESS

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MICHAELMAS TERM, 1981. [i.e. 1982] "T"

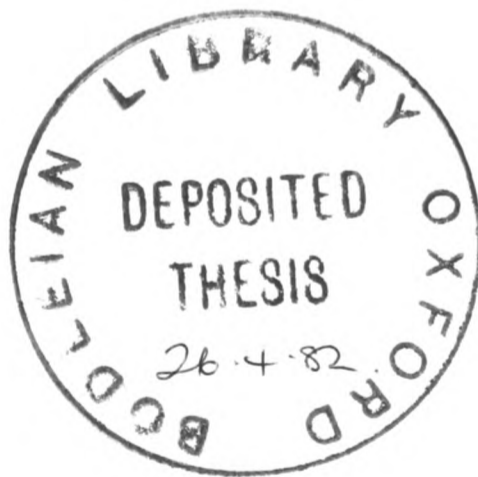
The arguments in the literature for and against "mental illness", are shown to founder on the lack of a thorough analysis of the sense of "illness" itself. Such an analysis is developed in the present study in three main stages. STAGE ONE: The ordinary use of "dysfunction" is examined. The term is shown to imply a particular kind of value judgement, derived, in respect of objects, from the purposes of living things for them. STAGE TWO: The sense of "illness" is interpreted from examples of physical illness by comparing and contrasting it with "dysfunction". An important logical link with "action" is identified, which provides an interpretation of the particular kind of negative evaluation implied by "illness". The relationship between "illness" and "disease" is examined in terms of this negative evaluation. STAGE THREE: The results of stage two are generalised from "physical illness" to "mental illness" by way of the notion of "action". "Mental illness" is examined as illustrated by examples of four main kinds of condition - organic psychosis, neurosis, addiction and functional psychosis. In respect of the first of these, "mental illness" is shown to be similar in its logical properties to "physical illness"; in respect of the remaining three, it is shown to be different, but in three quite distinct ways. In each case, however, the properties of "mental illness" are derived consistently with the interpretation of "illness" developed from examples of physical illness in stage two. "Mental illness" and "physical illness" are thus shown to be logically equivalent. In a concluding section, the implications of this result for the debate about "mental illness" are examined.

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I. INTRODUCTION

SUMMARY: The form of argument that is adopted generally in the literature by the opponents of the concept of "mental illness" is shown to be closely similar to that which is adopted by its supporters. This suggests an alternative strategy for analysing "mental illness", and certain requirements that any such analysis should satisfy.

1. There has been until recently in medicine perhaps little need for conceptual analysis. The meanings of those terms "illness", "disease", "symptom", "sign", and so on, that characterise the language of medicine, and by which therefore the conceptual structure of medicine itself is defined, have seemed, by and large, to be self-evident. And if not self-evident, at least self-evidently irrelevant in the day to day practice of medicine. Certainly, if the relative attention in the literature to conceptual and to practical issues is any guide, such conceptual difficulties as may have been apparent in the past, must have been of negligible interest and importance set against the number and variety of urgent clinical problems with which the practice of medicine was concerned. For, with the possible exception of classical authors, questions of meaning have been until the present century rather pointedly ignored by physicians and philosophers alike.

2. The concerns of clinical practice then, having been largely practical, the theoretical

programme of medicine has been correspondingly empirical. However, in parallel with the rapid progress of this empirical programme in recent years, a variety of problems have appeared in clinical practice itself that are neither practical in nature nor susceptible of empirical solution. Some of these problems are straightforwardly moral and political, concerning issues such as the proper extent of treatment in terminal illness, or the just distribution of limited health care resources. But there are others that either raise directly or reflect difficulties that are conceptual in nature. In the past, for example, that central clinical question, whether someone is ill, has been largely an empirical question, the sense of the term "illness" being taken to be self-evident. But now, for different reasons in different kinds of case (several of which we examine in detail in Section IV), the same question may arise even though the plain facts, as it were, are not in doubt. And in such cases, in so far as it is the sense of "illness" that is called into question, the issues raised are conceptual rather than empirical in nature.

3. It is no coincidence that the increasing prominence of conceptual difficulties in the practice of medicine should have paralleled the success of the empirical programme upon which clinical practice has relied. On the contrary, it is the very success of scientific medicine that

has led to the emergence of these conceptual difficulties at the present time. For the very knowledge that has strengthened the medical profession in the treatment and control of illness, has produced two opposing pressures on the sense of the term "illness". On the one hand, the success of medicine has led to an opportunist tendency to subsume an ever wider range of human problems to the notion of "illness" (Lemkau et al., 1953). The idea, for example, that crime should be regarded as an illness, although suggested by Plato in *The Republic*, and returned to here and there by subsequent generations of philosophers and reformers, has gained significant public sympathy and support only in recent years (Wootton, 1959). On the other hand though, because this same success implies an increasing capacity for influence and for control, a tendency in the opposite direction has become apparent also; a tendency, that is, to deny the status of "illness" even to certain conditions traditionally recognised as such. Insanity provides the best current example of this latter tendency, there being now a widespread view that psychiatry as a whole, at least as a specifically medical discipline, should be dispossessed (e.g. Foucault, 1967; Laing, 1967; Sarbin, 1967, 1969; Szasz, 1960, 1963, 1973, 1976; and so on). It is between the pressures of these opposing tendencies, which are themselves equal and opposite products of the success of scientific medicine,

that the concept of "illness" has become squeezed.

4. Specifically conceptual difficulties have not however appeared uniformly throughout the practice of medicine. Indeed, although empirical methods have been until recently applied with most success in physical medicine, it has been psychological medicine that has presented the greater conceptual difficulty. And it is presumably in consequence of this, that the concepts employed in psychological medicine, in particular that of "mental illness" itself, have been very widely assumed to be logically inferior in some way to those employed in physical medicine. In the literature, indeed, this pejorative assumption appears to be shared equally, though not equally explicitly, by those who oppose and by those who support the concept of "mental illness". For the concept is in effect presented respectively either as deserving attack or as requiring defence; conceptual analysis, such as it is, being employed either for condemnation (e.g. Laing, 1967; Sarbin, 1967, 1969; Scheff, 1963; Szasz, 1960, 1963, 1973, 1976) or for justification (e.g. Boorse, 1975, 1976; Flew, 1973; Glover, 1970; Kendell, 1975; Lewis, 1953) of the concept, rather than, in a spirit of neutral enquiry, for clarification as such.

5. This pejorative view of the concept of

"mental illness" has influenced also, and, as we shall see, in many cases has largely determined, the strategy that has been adopted in the literature for interpreting it. For, just as it may seem that because the use of "illness" in respect of mental illnesses is commonly contentious, the sense of "mental illness" must be obscure and possibly logically defective, so it might seem that because the use of "illness" in respect of physical illnesses is relatively uncontentious, the sense of "physical illness" must be self-evident and logically unexceptionable. And given this further assumption, it would follow that the sense of "mental illness" may be interpreted by comparing examples of mental illness directly with examples of physical illness; and that the notion of "mental illness" itself, stands to be justified or condemned by the results of this comparison.

6. Not only, then, is a pejorative assumption about "mental illness" common to opponents and supporters of the concept, but this assumption has resulted in the two sides following closely similar forms of argument. The parallels between them are well illustrated by Szasz (1960) and Kendell (1975), whose opinions, as critic and as advocate respectively of the concept of "mental illness", we will now compare (other authors will be mentioned in subsequent sections.) Kendell (1975) notes that, "before we can begin to decide whether

mental illnesses are legitimately so called we have first to agree on an adequate definition of illness..."; he then considers various physical illnesses and concludes that what distinguishes... "illness from non-illness"...is..."biological disadvantage...", which he takes to mean lowered fertility and/or reduced life expectancy. He concludes therefore, that, since conditions like schizophrenia are, in this sense, biologically disadvantageous, the argument that..."there is no such thing as mental illness..." is clearly wrong, because..."at least part of the territory regarded by psychiatrists as mental illness fulfills the same criteria as those required for physical illness." Kendell argues in effect, that certain mental conditions are mental illnesses, and that mental illness therefore exists, because these conditions are like physical illnesses in some respect which is crucial to the sense of "illness" itself. Szasz (1960), however, comes to precisely the opposite conclusion, though the form of his argument is essentially the same. He writes, for example..."the concept of illness whether physical or mental implies deviation from some clearly defined norm." However..."in the case of physical illness..." (and here he draws like Kendell on uncontentious examples of physical illness such as syphilis of the brain)... "the norm is the structural and functional integrity of the human body..." and hence..."what health is can be stated in anatomical and physiological

terms...". But, argues Szasz, the norms for (so-called) mental illness..."must be stated in terms of psychological, ethical and legal concepts...", and mental illness therefore..."cannot be explained by a defect or disease (of the body)...". Hence, mental illnesses differ crucially from physical illnesses, so that..."there is no such thing as mental illness".

7. The parallels between the arguments adopted by these two authors, therefore, are most striking. For both, it is the sense of "mental illness" that is regarded as the problem; both turn to examples of physical illness; and both turn to such examples as paradigmatic of the sense of "illness". The notion of "mental illness" is then interpreted by both authors by comparing examples of mental illness with these paradigmatic examples of physical illness. And the sense, or conversely the non-sense, of the notion of "mental illness" is taken to be established against the standard that is set by the sense of "physical illness". However, where Kendell draws attention to a similarity between "mental illness" and "physical illness", Szasz emphasises a difference. For Kendell, that is to say, what is crucial to the sense of "illness" as instantiated by examples of physical illness, is "biological disadvantage", which physical illnesses share with mental illnesses.

For Szasz, however, "illness" is defined crucially in terms of deviation from anatomical and physiological norms, and such norms are available only for physical illnesses. Both authors, therefore, proceed by comparing examples of mental illness with examples of physical illness, arguing to opposite conclusions by emphasising respectively the similarities and the differences between them.

8. What is wrong with the argument in this form must now be clear enough. It is a presupposition of the argument itself that "mental illness" and "physical illness" are similar in certain respects and different in others. They are, for example, similar in that both are taken to be "illness", whether or not legitimately so; and they differ in that examples of "mental illness" are more commonly contentious than examples of "physical illness". However, the form of argument as adopted generally in the literature (for Kendell and Szasz merely illustrate the point) provides no mechanism for determining which of these similarities and/or differences are crucial to the sense of "illness". Hence the issue of the validity of the notion of "mental illness" must be decided by a process of selection from among these similarities and differences, that is at best arbitrary, and at worst dictated by the preconceptions of the author concerned.

9. The net result of these considerations must be to reverse the assumptions upon which the conventional form of argument relies. For if different authors, adopting this form of argument, come to contrary conclusions, and if the main difference between them is which features of their examples of physical illness they take to be crucial to the sense of "illness", then the sense of "illness" itself in these examples cannot be self-evident. The sense of "illness", that is to say, may be apparent in examples of physical illness, but it is not transparent. But, if the sense of "illness" is not self-evident in examples of physical illness, there is no justification for arguing direct from such examples to the sense of "mental illness". Examples of physical illness, being uncontentious, may appropriately be adopted as paradigm cases of "illness". But a much more thorough going analysis of such examples is required if the sense of "illness" is to be derived from them. Indeed, the very difficulties that are presented by the use of "mental illness", far from having led to an assumption that "mental illness" is the problem, might perhaps equally well have suggested that the notion of "physical illness" is not so straightforward conceptually as it appears. For the fact that conceptual difficulties are presented by "mental illness" in clinical practice more commonly than by "physical illness", in itself shows only that

psychological medicine is conceptually more difficult than physical medicine, not that its conceptual structure is defective. Rather than arguing direct from "physical illness" to "mental illness", therefore, the form of argument that is suggested by these considerations, must be from uncontentious cases of the use of "illness", whether in respect of mental or physical illnesses, to the sense of "illness", and so by way of generalisation to an interpretation of those cases that are obscure.

10. Understood in this way, then, the conceptual difficulties that are presented by "mental illness" in clinical practice have alerted us to the need for a critical reappraisal of the conceptual structure of medicine as a whole. This is not to presuppose that "mental illness" is logically sound - but it is to recognise that the difficulties presented by it in clinical practice, far from being in themselves prejudicial to psychological medicine, have important positive implications. And indeed, in provoking conceptual enquiry, the contribution of psychological medicine may well prove to be a contribution to medicine not only in its clinical aspects but as a scientific discipline as well. For the slower progress of empirical research in psychological medicine, although no doubt due in part to the extreme practical

difficulties of the subject, may be a result also of its greater conceptual difficulty. And if this is so, clarification of these difficulties should inform our understanding of empirical research itself; possibly removing confusions which, although pragmatically unimportant thus far, at least in physical medicine, might nonetheless hinder the future development of medicine as a scientific pursuit.

11. To reinterpret the "problem of mental illness" in this way, is however, to do nothing either to simplify the problem, or to reduce or restrict the scope of the conceptual difficulties that are implied by it. These, on the contrary, are at least doubled. For not only must the notion of "mental illness" be explored conceptually, but that of "physical illness" also, the sense of neither being taken to be self-evident. And this exploration to be complete, must explain, rather than taking for granted, the properties of both. It must show, for example, not only why "mental illness" is often contentious in ordinary use, but also why "physical illness" is not - for once the nature of the problem is properly understood, the apparent lack of conceptual difficulties presented by "physical illness" becomes as much an issue for analysis as the manifest conceptual difficulties of psychiatric

practice that drew attention to the problem in the first place. And indeed, more generally, far from merely comparing "physical illness" and "mental illness" in respect of some particular feature, the analysis, if it is to proceed by way of generalisation from examples of physical illness to examples of mental illness, must in principle do justice equally to the similarities and to the differences between them.

12. But if the issues for analysis are thus multiplied by our re-interpretation of the problem, our view of the kind of analysis that is appropriate is correspondingly restricted. In the literature, as we have seen, "mental illness" is conceived as the problem, and the conceptual structure of psychological medicine is therefore assumed to be unsatisfactory compared with that of physical medicine. The tendency therefore, has been to turn for improvement to one or more of those topics in general philosophy that bear most immediately on the differences between the two kinds of medicine. Most obviously, perhaps, if "mental illness" is taken to be the problem, it may seem that it must be the "mind" in "mental" that is the source of our difficulties - and hence that modern accounts of the mind-body problem might help to resolve these (e.g. Boorse, 1976; Roth, 1976; Szasz, 1961; Wing, 1978).

Similarly, if psychological medicine has developed more slowly than physical medicine as a scientific discipline, it may appear that the philosophy of science will be pertinent (e.g. Slater, 1972, 1973, 1975; Boorse, 1975; Wing, 1978). Or that, if "disease categories" in psychological medicine are relatively unsatisfactory, they may be clarified either by an application of the logic of classes (Kraupl-Taylor, 1971, 1972, 1980) or by removing "primitive" misconceptions about the nature of "disease entities" (hence frequent references to the nominalist-essentialist controversy - e.g. Campbell et al., 1979; Kraupl-Taylor, 1979; Scadding, 1967; Wulff, 1979).

13. In the present study, however, in identifying "illness" generally, rather than "mental illness" in particular, as the problem, the approach that appears most obviously pertinent is that of logical, or conceptual analysis. We will, in fact, adopt at each stage in the argument, an essentially Aristotelian strategy (Ackrill, 1973): viz., an initial examination of the "phainomena" (in this case, the facts of our ordinary use of medical language; which facts are treated as a guide to the received conceptual structure of medicine); formulation of difficulties (obscurities, contradictions, puzzles), often by juxtaposition of "phainomena"; and finally,

an attempt to resolve these difficulties within, rather than by departing from, the larger-scale features of our ordinary conceptual scheme, within which the conceptual structure of medicine itself is set.

14. The justification for adopting this strategy, then, is that the conceptual difficulties presented by "mental illness" in clinical practice, are taken, in the present study, to indicate the need for a thorough reexamination of the concepts employed in medicine as a whole; and this need is likely to be met most directly by linguistic analysis. We shall not therefore attempt to explore all those philosophical topics that might appear, from a more conventional view of the "problem of mental illness", to be relevant. Indeed, in many instances, as we shall see in the course of the argument, it will be our ordinary conception of certain notions (e.g. "action", II:2/3, III:2A, IV:2; "pain" and "sensation", III:2B; "mental" and "physical", III:5; "appetite", IV:3B; "reason", IV:4) that will be relevant where these notions occur in, or as part of, the conceptual structure of medicine. For, a fortiori, it is our ordinary conception of these notions, rather than any particular philosophical account of them, that is incorporated in our

ordinary conceptual scheme, and so in the conceptual structure of medicine itself. It may be, of course, that certain of the conceptual difficulties that we find in medicine, are a product of the ordinary properties of these notions; and if so, philosophical insights into these properties may prove pertinent to resolving these difficulties. Indeed, a main theme of our argument will be that many of these difficulties derive from, and so may be explained in terms of, the status of "illness" and "disease" themselves as value terms - and we will therefore draw on philosophical accounts of the logic of evaluation. But for all this, the way to general philosophy in the present study will be by way of detailed, linguistic analysis of the relevant areas of our ordinary conceptual scheme, rather than by way of over-simple, over-general, and premature assumptions about the nature of the problems presented by "mental illness".

15. A proper recognition, therefore, of the nature of the "problem of mental illness", widens our view of the scope and complexity of the problem, and it places clear constraints on the kind of analytical enquiry that is appropriate, at least in the first instance. In addition, however, it alters, and in some respects reduces, our expectations of what we may hope to achieve by such an enquiry.

In particular, we must anticipate that the results of analysis may actually increase, rather than diminish, the demands of clinical practice, within which, as we have seen, the "problem" itself first became apparent. For the recognition of the fact that the sense of "illness" is not self-evident even in uncontentious examples of the use of the term, leads inevitably to the prediction that any competent interpretation of it must go beyond the obvious. Such an interpretation, therefore, if it is to impinge on those conceptual difficulties in the practice of medicine towards which it is directed, will demand some effort of assimilation on the part of practitioners themselves. And similarly, if it is found that the ready assumptions that are quite proper to large areas of clinical practice must be, in other areas and for certain purposes, set aside, then the conceptual demands of the practice of medicine as a whole will be greater, not less. Indeed, it may be that doctors schooled, as they are, in empirical medicine, may find even the kind of answer that is supplied by analysis wholly unfamiliar. Analysis, for example, may provide no determinate answer to whether a particular condition, such as homosexuality, should be regarded as a disease. Analysis would be committed to clarifying the issues involved in such a question, but not to a determination of the question as such. As to the utility of such objectives, only the results of analysis itself may speak.

II. ILLNESS AND DYSFUNCTION

SUMMARY: Attention is drawn to the differences in ordinary use between "illness", "disease" and "dysfunction". An analysis of "dysfunction" is then developed which prepares the way for subsequent analyses of the more complex notions of "illness" and "disease".

II:1. ILLNESS, DISEASE AND DYSFUNCTION

1. There is in our everyday conception of things, a very general tendency to identify the notion of "illness" with that of "disease", and to identify both these notions with that of "dysfunction", of something "not working properly". The Shorter Oxford English Dictionary, for example, includes "disease" as a synonym for "illness", and defines "disease", *inter alia*, as a "condition of the body...in which its functions are disturbed or deranged." Dictionary definitions, of course, embody those assumptions that govern our ordinary use of language; and these assumptions, to some extent, must be carried over into linguistic analysis. But since it is these same assumptions that issue in the very confusions and difficulties of ordinary use that analysis should explicate, their place in analysis must be that of subject rather than that of premiss.

2. The literature, however, or the medical literature at least, on the concepts of "illness"

and "mental illness", is remarkable for its uncritical adoption of these ordinary use identifications. Thus, with certain exceptions (discussed more fully in Section III:3), "illness" and "disease" are treated, as in the Shorter Oxford English Dictionary, as synonyms; and the meaning of this composite notion, "illness/disease", is commonly interpreted in terms of "dysfunction". Indeed, apart from pragmatic, though circular, definitions, such as "illness" being that which "doctors treat", (Stafford-Clark in Pakenham, 1958), or that which elicits "therapeutic concern", (Kraupl-Taylor, 1971, 1976, 1979); and apart from avowals of ideals of "health", which notion includes, but is not limited to the absence of "disease" and "illness", (World Health Organisation, 1948; Jahoda, 1958), it is generally taken for granted that the notion of "illness/disease" either means, or in some logically crucial respect, may be reduced to, the notion of "dysfunction".

3. Thus the most important issue for analysis would seem to be what sorts of "dysfunction" the notion of "illness/disease" may properly be taken to imply. And this, indeed, is the point around which much of the debate about the validity of the notion of "mental illness" revolves (I;8). Szasz (1960, 1963, 1976), as we have seen, together with Albee (1969), Eysenck (1960) and Sarbin (1969),

would in effect limit "illness/disease" to dysfunction of bodily organs and systems. Other authors, however, including many famous names in the history of psychiatry itself, while adopting a similar view, allow disturbance of mental function provided there are "grounds" for supposing some underlying, though as yet undiscovered, organic disturbance; Jaspers (1913) and Kraepelin (1917), for example, and more recently Schneider (1950), and Wing et al., (1973), have all expressed views along these lines. Still others would include disturbance of mental function either in its own right (Farrell, 1979; Kubie, 1954), or because of some property that disturbance of mental function has in common with disturbance of bodily function. As to which of these common properties should be regarded as logically crucial, the suggestions in the literature are protean. As we noted in Section I in connection with Kendell's views, "biological disadvantage" is one such suggestion, the same expression being used by Scadding (1967); while Hill (1968) and Boorse (1975 and 1976) have written similarly in terms of deviation from normal biological function; and Freed (1969) and Roth (1963) have echoed the classical view (e.g. Plato in *The Republic*) of "disease" as an imbalance between different functions. But other suggestions include disturbance of "part-function" (Fine, 1967; Lewis, 1953); behavioural disorder (Redlich and Freedman, 1966); diminished adaptive

capacity of social groups (Fabrega, 1976); and disturbance of individual social functions, within society (Edgerton, 1969; Keller, 1960; Sarbin, 1969), or within the family (Sagar and Kaplan, 1972), or in interpersonal relations (Menninger, 1930). And so the list continues. But, as we suggested in paragraph 2, in all these accounts it is generally taken for granted that "illness/disease" should be analysed in terms of "dysfunction", of one sort or another.

4. There are, however, notable exceptions to this. Thus, Flew (1973) described definitions of "disease" that follow what appears in the Shorter Oxford English Dictionary, as "too broad", in that they fail to distinguish "disease" from disturbance of function due, for example, to congenital defects and wounds; and Hare (1978) made a similar cautionary point. And indeed, ordinary use itself, while displaying clear indications that the three notions are closely related logically, contains equally clear indications that this relationship is not one of simple equivalence of meaning. Thus, the conventional referents of the terms are different. A person, for example, may be said to be ill or to have a disease, but not, qua "illness/disease", to be dysfunctioning: a person's body, or a part of their body, might be said to be not working properly in this sense, but not the person. Not only that,

but a central use of "function" occurs in respect of machines and the parts of machines; and machines, other than figuratively, neither fall ill, nor do they get diseases. Furthermore, there are differences of this kind, even between "illness" and "disease". The use of "disease", for example, in respect of plants is familiar enough, but the use of "illness" is not. A similar, though less marked, differential occurs in respect of animals; "falling ill" being used conventionally perhaps only in respect of domestic pets (which are, after all, treated and thought of in some ways as persons), "disease", or sometimes the less specific term "sick", commonly being preferred.

5. We will return to these differences in more detail in the course of subsequent sections. But we should note for the present that they are no mere stylistic conventions. For while the terms "illness" and "disease", and even "dysfunction", may in certain contexts appear to be used as synonyms, in other contexts their meanings are clearly different. Indeed, the terms "illness" and "disease" themselves, may be used not merely to express different meanings, but contrastingly. A diabetic, for example, controlled on insulin, might be said to be "perfectly well", or "never ill", despite his "disease". Furthermore, our ordinary assumptions as to meaning notwithstanding, the translation of an expression such as "he is ill"

directly into terms of "dysfunction", ("he is not working properly", for example, or even "he is dysfunctioning"), would be not only awkward and unfamiliar, as a breach of verbal convention might be, but actually misleading. For while it is true that if "he is ill" then "there is something wrong with him", just as, if a machine is "not working properly" there is "something wrong with it", the expression "he is not working properly", used in respect of a person, would be taken to mean, not that "he is ill", but rather that "he is not doing his work properly". And, in references of this sort, if "not doing his work properly" is constitutive of "dysfunction" at all, the functions concerned would be those served by the person's role in society, rather than those that would be identified ordinarily with "illness" and "disease". In ordinary use itself, therefore, although the terms "illness", "disease" and "dysfunction" are closely related in some way, they are not equivalent in meaning.

6. But if this is so, the strategy so widely adopted in the literature, of discussing the senses of both "disease" and "illness" in terms of "dysfunction", must be in error. And seriously so, for while the origin of this strategy is clearly the tendency in our ordinary conception of things to identify these notions, ordinary use

itself, observed comprehensively, shows that this identification does not consist in simple identity of meaning. The conventional strategy in the literature, therefore, may be understood as relying on one aspect of ordinary use, (that in which "illness", "disease" and "dysfunction" may be used as synonyms), while, at the same time, ignoring the important logical differences between them that ordinary use exhibits. But analysis, if it is to rely on ordinary use at all, must surely rely on the features of ordinary use as a whole. After all, if a merely piecemeal adoption of the features of ordinary use were justified, the difficulties presented by ordinary use might just as well be ignored as interpreted.

7. In Section I, we suggested that an initial step in analysing the difficulties presented by "mental illness", must be to look more critically at our assumptions about the sense of "illness" and "disease" generally. And a first result of this more critical approach has been to disentangle "illness" from "disease", and both from "dysfunction" in ordinary use. Nonetheless, as we have seen, ordinary use impartially examined, does suggest that there is some close and presumably important, logical link between these notions. And since we may suppose, from the reductionist strategy adopted

conventionally in the literature, if for no other reason, that "dysfunction" is conceptually the more straightforward of the three, an analysis of "dysfunction" may usefully precede analyses of "disease" and "illness".

II:2 DYSFUNCTION

1. The use of any term involves distinguishing between the notion that is expressed by that term and other related notions. These distinctions may be of greater or lesser conceptual significance, and they may be drawn with a greater or lesser degree of difficulty. An important distinction in the case of "dysfunction" is, of course, between the notion of "not functioning properly" and that of "functioning properly". (The term "dysfunction" is used here without technical connotations, simply as a compressed form of the expression "not functioning properly"; the two forms of words, therefore, should be taken to be equivalent in meaning in the present study.) This distinction would seem to be drawn perhaps most readily in the case of machines. For among the many classes of things to which "dysfunction" is ordinarily applied (II:1;4), its use in respect of machines is least commonly subject to doubt or dispute. Machines therefore, will tend to provide the most straightforward examples of the use of "dysfunction"; examples which should most readily display the basis of the distinction between "dysfunction" and "normal function". In the present section then, in analysing "dysfunction" by way of this distinction, we will tend to consider "mechanical dysfunction" first, and "bodily dysfunction" by comparison with it, even though the latter is perhaps

closer conceptually to our target notions of "disease" and "illness".

2. Familiar everyday examples of machines not functioning properly are provided by motor cars. A car, for example, would in many circumstances be taken to be not functioning properly if it swerved suddenly across the road. Not in all circumstances, however. For cases of swerving in which the car in question is taken to be not functioning as it should, would ordinarily be distinguished from cases in which, for example, the car skidded on a patch of ice, or was hit by another car, or had been driven incompetently, or even driven deliberately into a swerve, perhaps to avoid an accident. And the common factor here, it may be said, is obvious enough - viz., in each of these latter cases, there is nothing wrong with the car itself. If the steering mechanism had jammed, or a tyre had burst, or there had been some other mechanical failure, then the car, in swerving, could properly be said to have been not functioning properly, but not otherwise.

3. This kind of case has obvious parallels with cases of bodily dysfunction, and hence may seem relevant to interpretations of "disease" and "illness". It suggests, for example, that the relationship between "disease" and "illness" (in so far as

these notions are distinct), may be analysed as one of cause and effect - "disease" being understood as a "disturbance of bodily function" which causes the symptoms and signs that constitute "illness". And, as we shall see in Section III:3, some such model of the relationship between these notions is commonly assumed in the literature. However, any temptation to adopt this model should be forestalled by an obvious difficulty. For the common sense distinction between "functioning properly" and "not functioning properly" that was suggested in the preceding paragraph, was drawn in terms of mechanical failure; and mechanical failure itself is a case of "dysfunction". Hence, failures of function may, as in the case of a car swerving, and in the case of disturbance of bodily function, be sequential; and the sequence concerned may well be one of cause and effect; but to distinguish an effect as a case of dysfunction simply on the basis of whether or not its cause is a case of dysfunction, is, for the purpose of analysis, circular and unhelpful.

4. There must, then, be some other feature of our example that is crucial to the required distinction. The next most obvious suggestion might perhaps be framed in terms of "abnormality".

And here, it may be said, we may avoid an empty tautology (viz., a simple equation of "dysfunction" and "abnormal function") by giving substantive sense to the notion of "normal". Not, in the case of a car swerving, by reference to the movements of the car as such - for these movements, by the standards of cars, are unusual, but, ex hypothesi, they are common to each of the cases mentioned in paragraph 2 - but by reference to the structure of the car. For, this suggestion might continue, what distinguishes mechanical failure, surely, is a deviation in the structure of the car from what it should be. And what its structure should be, may be established in principle, and usually in practice also, either from the maker's specification, or from experience of cars of the type in question.

5. At first sight, this suggestion certainly looks more promising. And there are correspondingly, as with our first suggestion, a variety of parallel accounts of "bodily dysfunction", and of "disease" and "illness", in the literature. The simplest of these are framed statistically, in terms either of the normal distributions of those characteristics of the organism that are taken to be pertinent (e.g. Cohen, 1943), or of some standard example of the "species typical" design (e.g. Boorse, 1975), in either case "abnormal" being taken to mean

"deviation from the norm". Such definitions however, as Farrell (1979), Flew (1973), and many other authors have observed, are subject to at least two obvious difficulties; that they fail to distinguish good from bad deviations from the normal; and that some diseases (e.g. dental caries) are in fact normal. Hence, an evaluative element may come to be included (implicitly or explicitly) in the definition, by way of a reference either to which side of the normal distribution is to count as negatively evaluated (e.g. Redlich and Freedman, 1966; Scadding, 1967; Hill, 1968), or to ideal, rather than merely typical, standard examples (e.g. Jones, 1932; King, 1945; Thorpe and Katz, 1948).

6. The addition of this evaluative element, however, is for some authors, and, as Farrell (1979) observes, for most doctors, unpalatable, because it is regarded as taking medicine out of the province of science. And certainly, etymological considerations notwithstanding, "dysfunction" would seem to be more obviously evaluative in some contexts than in others. The norms of social function, for example, and of certain kinds of mental function, would commonly be regarded as reflecting the values of society; while the question of whether or not a machine or bodily part is not functioning as it should would

seem to be settled by reference only to factual considerations. We will examine this question in detail in Section II:4. For the present, however, we may note that even if "dysfunction" is a value term (and we will suggest in Section II:4 that it is), the recognition of this, as it stands, fails to provide for a sufficient definition of it, let alone of "disease" and "illness". For what is implied by the use of these terms, in so far as they are value terms, is a particular kind of negative value. It is not, for example, or not primarily, moral or aesthetic value. And attempts in the literature to circumscribe the relevant kind of value, tend either to be question begging (e.g. many of those definitions noted in Section II:1, in terms of "maladaptation", "biological disadvantage", and the like), or frankly tautological (e.g. in terms of "pathology", Gregory, 1968).

7. These difficulties are apparent also even in respect of "mechanical dysfunction", which is perhaps the best candidate among species of dysfunction for a value free definition. Thus, in our present example of a car swerving, the swerve may well be the result of a deviation from normal in the structure of the car; but not all such abnormalities result in or constitute dysfunction. Substitute parts,

for example, even from a car of a quite different design, may perform as well or better than those that are normal for a car of that type. And negatively evaluated deviations in the structure of the car would include deviations of aesthetic as well as of functional significance.

8. The notion of "abnormality" is nonetheless an important notion in relation to "dysfunction", and our example illustrates two ways in which this is so. In the first place, while dysfunction may be normal (statistically), normally it is not so. Hence, if a machine departs from our expectations of it (as when a car swerves), this will raise the possibility, and/or draw attention to the fact, that it may not be functioning properly. In the second place, while a cause-effect analysis is not a sufficient analysis of "dysfunction" (paragraph 3 above), cause-effect accounts of "mechanical dysfunction" (i.e. of the causes and consequences of dysfunction, which may or may not themselves be cases of dysfunction) may nonetheless involve references to the standard structure and operation of the parts of the car, as established either from experience or from the relevant operational manual. Clearly, the notion of "abnormality" may be relevant also in both these ways, in respect of bodily dysfunction. But for all that, in neither kind of case, mechanical or

bodily, is the notion of "abnormality" logically crucial to that of "dysfunction".

9. It would seem then, that the basis of the distinction between "functioning properly" and "not functioning properly", is not self-evident even in respect of those normally uncontentious examples of the use of "dysfunction" in respect of machines. For neither of the two suggestions that we have considered in the present section have stood up to examination, even though both are reflected widely in the literature in definitions of "bodily dysfunction", and of the closely related notions of "illness" and "disease". We must therefore look, as it were, behind the "obvious" distinction between "dysfunction" and "normal function", at the notion of "function" itself.

II:3 FUNCTION

1. In Book I of The Republic, Plato defines the "function" of anything as ... "that which only it can do or that which it does best". Hence it would seem, to function is to do something. And this certainly would seem to accord with our example in the preceding section of a car swerving. For "something wrong" in this kind of case does appear to be distinguished (II:2;2) as something that the car does from things that are done or happen to it: being driven incompetently or deliberately into a swerve, being things that are done to the car; skidding on ice or being hit by another car being things that happen to it. This distinction, furthermore, would seem to be of some general significance. For the relevant sense of "do" would seem to be very wide; to include, for example, "not-doing", as in the distinction between a car failing to start and not being started; and, indeed, "doings" that do not involve movement at all, as in a reference, for example, to what a paper weight does.

2. We will return to this sense of "do" subsequently in this section. It is, however, as drawn, too comprehensive in two related respects. In the first place, it fails to provide for the distinction

between "dysfunction" and "normal function"; for these, clearly, are both species of function, and hence, in the sense in question, they are both things that are done. In the second place, however, it fails also to characterize adequately the sense even of "function". For in this sense of "do", non-functional as well as functional objects are said to do things; and in references of this sort, what they do is distinguished from things that are done or happen to them. Rivers, for example, flow; but they are polluted or diverted. Nor indeed, to revert to Plato's definition, is the sense of "do" sufficiently restricted by limiting it to the particular things that a particular object can do (... "only it can do, or ... does best), for this restriction also would apply to non-functional as to functional objects.

3. What is missing from the definition, however, is suggested by a different formulation that Plato gives a few lines earlier (Plato himself, seems to regard the two definitions as equivalent) - that the function of anything is ... "something one can only do, or does best, with the thing in question". The operative word in this definition is "one". For Plato's use of "one" implies that the sense of "do" in "function", derives in part at least from the sense in which people do things. Now, the

sense in which people do things is, in our ordinary conception of the notion (which, as we suggested in Section I, is the relevant frame of reference) different from that in which objects do things. Just what this difference consists in, is, of course, the subject of long standing philosophical debate. But an important, if not primary component of our ordinary understanding of the sense in which people do things, is that people, in what they do, serve, or may serve, their purposes. People, in this respect, are like other living beings, though the particular kind of purposeful activity that we attribute to them tends to be different - "intentional action", for example, is attributed centrally to people, together with a range of associated notions, "voluntary action", "conscious purpose", "deliberation", "foresight", and the like (we discuss these notions further in subsequent sections). But objects, which here includes bodily parts and organs as distinct from the living beings constituted by them, do things purposefully only in the sense that "their" purposes are the (not necessarily conscious) purposes of living beings for them. Hence the main burden of Plato's use of the word "one".

4. One further refinement, however, is required, and this also is suggested by Plato's account. In paragraph 2 above, we noted Plato's

use of the words "only" and "best". These indeed, occur in both his definitions of "function", and, as we observed, they imply a restriction on the sense of "do" as in "function". This restriction we must now re-introduce, but in a different way. In paragraph 2 we noted that objects have properties that are particular to them, but, since this is true of objects generally, it did not provide for a sufficient characterization of the sense of "function". However, it follows from the fact that different objects have different properties, that objects will vary in the extent to which they serve, or may serve, people's purposes. Hence, functional objects may be understood broadly as being differentiated from objects generally, as those that serve people's purposes; and particular functional objects are differentiated one from another by the purposes they serve and the ways in which they serve them. A stone, for example, with particular properties such as heaviness and smoothness, may be a sling shot or a paper weight in virtue of these properties; and which it is, will depend on the particular purpose it is intended to serve by virtue of these properties.

5. With the introduction of this notion of the particular, we have, in principle, sufficient for the characterization not only of the sense of

"function", but also of the distinction between good and bad function. For, the function of something may now be understood as the particular way in which, in virtue of its particular properties (viz., in virtue of what it "does"), it serves some particular purpose of people (or of other living beings) for it. And hence, "good function" and "bad function" follow straightforwardly in terms of the degree to which such service is successful. As Plato put it, ... "it is a thing's characteristic excellence that enables it to perform its function well, while its characteristic defect makes it perform it badly". In our original case then, of a car swerving, "function" is distinguished, as we saw at the beginning of this section, as something that the car itself does. And the relevant sense of "do" is that which we have identified as the particular properties of cars. But "dysfunction" is distinguished from among the things that cars do, as those in which it fails to serve people's particular purpose for cars. Hence, a car that fails in what it does (i.e. in virtue of its properties), to serve a purpose other than its particular purpose, for example as a battering ram or a food store, would not, or not necessarily, be not functioning properly.

6. The logical importance of this notion of "particular purpose" may be brought out by considering what would be required for a non-human being to determine whether a car is functioning properly if this being had no prior knowledge of human beings (similar determinations, of course, are carried out in respect of archaeological "finds"). We will assume that this non-human being shares the human notion of "function"; and that he knows that the car in question is a functional object. It is clear that, for such a being, observations of the car would not in themselves be sufficient. For, in the first place, (consistently with the results of Section II:2), even if the car is doing something that is different from what most cars do, this will not distinguish good from bad function; and the same would be true of observations of its parts. But, in the second place, such observations would not amount even to a conclusion about which properties of the car are pertinent to its function. For cars, as Hempel (1965) has observed in respect of biological functional "objects", have many "adventitious" properties - they spray carbon monoxide, they smear rubber on the ground, they are externally hard, and often shiny, and so on. Now it may seem that it is absurd to suggest that these could be considered to be pertinent properties. But the absurdity of the suggestion would consist in the extent to which it departs from

our knowledge of what people's purposes for cars actually are. And this knowledge our non-human being does not possess. Hence, for such a being to establish the function of a car, and so whether or not it is functioning properly, he must (logically) discover first the particular purpose of cars. And this purpose therefore, is logically crucial to the sense of "function" and to that of "dysfunction" also.

7. We have, then, in the present section, provided an interpretation of the distinction between "dysfunction" and "normal function", in effect by tracing its logical dependence on the notion of "function" itself. In this, however, we have avoided a trap which is not avoided in the literature on "mental illness"; and which therefore we will note briefly by way of a conclusion to the present section. The trap, essentially, was set by our original choice of examples of "dysfunction", and the assumptions that led to this choice. Examples of machines not functioning properly, we observed, were in general relatively clear and uncontentious compared with examples of bodily parts and organs (II:2;1). Hence it seemed that the sense of "dysfunction" should be displayed particularly clearly by examples of "machine dysfunction". And, indeed, such examples did lead to the required basis for the distinction between "dysfunction" and "normal function".

Furthermore, a series of important conclusions about "bodily dysfunction" were derived in the course of the discussion, and a similar analysis of this latter kind of dysfunction was assumed throughout (Plato, of course, uses examples of the two kinds of dysfunction, bodily and mechanical, interchangeably). There is however, one respect in which "bodily dysfunction" differs from "machine dysfunction". For the "particular purpose" of a machine is the purpose for which it was made, and in respect of machines this purpose is sharply distinguished from other purposes to which it may be put, even conventionally. The proper purpose of a car is not that of storage even if it is used only for this purpose. But bodily parts are not "made", in the required sense, their particular purposes indeed being derived as the purposes for which they are used conventionally.

8. Now this difference between machines and bodies relates obviously enough, on our present account, to our original observation that cases of "machine dysfunction" are less commonly contentious than those of "bodily dysfunction". Thus, on this account, the particular purposes of functional objects generally are derived from among their properties, as those that serve people's purposes. In the case of bodily parts, this process is one that

is essentially passive - in effect, we just find out what their functions are; and the process may be more or less continuing, and more or less complete. But for non-bodily objects the process is an active process of selection and/or modification - and this, as it were, in principle fixes the functions of such objects once and for all. But the trap in this would now be sprung if, in our original adoption of cases of "machine dysfunction", we had assumed that the particular lack of contention that attaches to examples of the use of the notion, was a product of the notion itself having some logical priority over that of "bodily dysfunction". For then the derived difference between them would imply, not that "mechanical dysfunction" is one special case of "dysfunction", but that "bodily dysfunction" is a logically weakened form of it. And the implications of this for our subsequent analyses of "physical illness" and "mental illness" are perhaps self-evident enough.

II:4 FUNCTION, DYSFUNCTION AND EVALUATION

1. The sense of "dysfunction" has been interpreted in the preceding two sections by way of an examination of the way in which it is distinguished in ordinary use from "normal function". In Section II:2, we raised, but then moved on from, the question of whether "dysfunction" may properly be considered to be a value term. This question, as we saw, arises essentially because the extent to which the notion is manifestly an evaluative notion varies in different contexts and from different points of view. In the present section we will examine the influence of this property of "dysfunction" on the literature, and the interpretation of it that arises from our present analysis of the term.

2. In the literature, then, one immediately obvious effect of the variable status of "dysfunction" as to fact or value, is seen in the debate between opponents and proponents of the concept of "mental illness". Much indeed, of the point of this debate could be understood in terms of this effect. For the debate hinges on the relative significance of the similarities and differences between "mental illness" and "physical illness"(I); but in the literature, "illness" and "disease" are generally indentified as, or reduced to, "dysfunction" (II:1); hence the more

overtly evaluative nature of "mental dysfunction" compared with "bodily dysfunction" (II:2), would seem to constitute one important difference between "mental illness" and "physical illness". Thus, Szasz, for example, uses this difference to sharpen the wedge that he seeks to drive between "mental illness" and "physical illness" (e.g. Szasz, 1961, 1976). Behavioural norms, which he takes to define "mental illness", are, he says, a matter merely of personal or, at best, corporate values. As such, then, the idea of "normal behaviour", and with it that of "mental illness", is subjective, vague, and unscientific. In effect, "mental illness" is merely a pejorative label, a tag that carries no more information than that society disapproves of the behaviour to which it refers. Contrast this, following Szasz's view, with the solidly factual notion of "physical illness" defined by the clear cut, objective, and fully scientific norms of bodily function.

3. Now it is clear that what gives Szasz's wedge its edge, as it were, is that he is able to play on what is perceived, even within the medical profession itself, as a potential weakness or flaw in the notion of "mental illness". That is to say, while Szasz's extreme view, that "mental illness" is a myth, would not be shared by a majority of his medical colleagues, a majority nonetheless would admit to some anxiety that "mental illness" is in some ill-defined way

less scientific than "physical illness". At the very least, for example, it would normally be admitted that the diagnosis of mental illness depends to a much larger degree than that of physical illness, on "personal" or "clinical" judgement. But then, the conventional view might continue, is this not "subjective"; and while "mental illness" may perhaps not be a matter simply of behavioural norms, norms of behaviour are after all involved; and do not such norms reflect the values of society; so, if the diagnosis of mental illness is subjective, could this subjectivity not derive from the notion being evaluative rather than factual; certainly the diagnosis of mental illness is less precise than that of physical illness; and so on. Grudgingly, therefore, within the establishment view itself, these and other similarly uncomfortable reflections seem to provide reluctant support for Szasz's claim that what counts as mental illness is determined by evaluative rather than factual considerations. But then, as Szasz himself suggests, do we not regard the success of medical science as resting on the adoption of precisely those objective standards that characterize bodily dysfunction, to the exclusion of merely personal prejudices of the kind that seem to be expressed by the notion of "mental illness"? We appear, therefore, to be on a slippery slope. The admission that

"mental illness" is more subjective than "physical illness, together with its associated anxieties, seems to take the conventional view more than half way towards Szasz's conclusion that the notion is an outmoded myth that should be summarily proscribed from the proper concerns of modern scientific medicine.

4. The slippery evaluative slope, however, such as it is, does not end with "mental illness". For if there are etymological indications that "dysfunction" may be touched with evaluation (II:2), "disease" itself, whether mental or physical, is touched similarly. And even if "disease" may be held firmly in place as a matter of fact, "illness" in medicine itself, let alone in everyday use, has persistently subjective and evaluative associations (e.g. Barondess, 1979; Taylor, 1979; the distinction between "disease" and "illness", and this aspect of it in particular, is discussed in Sections III:3 and III:4). The anxieties upon which Szasz is able to play therefore in respect of "mental illness", extend, albeit with less intensity, to the notions of "illness" and "disease" generally. But these notions, after all, are the defining notions of medicine itself. So, if Szasz's strategy threatens the scientific status of psychological medicine, it would seem to threaten also the scientific status of medicine as a whole.

5. That this threat, represented by the evaluative associations of "disease" and "illness", is no mere construction of speculative over-elaboration, is evident, if in no other way, from the volume of literature devoted to attempts at forestalling its effects. Indeed if the pressure which is apparent so generally in the literature (II:1), to reduce "illness" and "disease" to "dysfunction", derives from the fact that "dysfunction" is prima facie conceptually the less complicated notion, possibly the most tempting aspect of this apparent lack of complication is that, in respect of bodily "function" at least, the notion seems to be so straightforwardly factual and objective. If, that is to say, at least "bodily dysfunction" appears to be a matter of fact rather than of value, this would seem to set an irreducible minimum to the scientific content of medicine. Or, to put the same idea differently, if the notions of "disease" and "illness" as technical notions in medicine, may be reduced to the supposedly factual notion of "bodily dysfunction", this reduction would seem to distil the properly "scientific" concerns of medicine in its modern form. Quite apart, therefore, from attempts by Szasz and others to split "mental illness" off from the proper concerns of medicine, the equivocal status of "dysfunction" as to fact or value, allows it a much more fundamental role as a defence against the perceived threat to the status of medicine as a science.

6. These considerations, which are implied more or less directly in much of the literature on "illness" and "mental illness", are made fully explicit and are relied upon by Boorse (1975, 1976). Boorse's programme amounts to an attempt to circumscribe what he takes to be the technical part of medicine, by defining the key concepts of the subject in a way that excludes value terms. Thus, he starts by distinguishing "illness", which he acknowledges to be an evaluative notion, from "disease"; he then defines "disease" in terms of a failure of certain "natural functions", which functions, he claims, must include the capacities for survival and for reproduction; but whether or not the capacities for survival and reproduction are impaired, is a matter of fact; hence, Boorse concludes, "disease" may be defined by reference only to matters of fact without introducing value terms. In the course of his argument, Boorse actually compares "boldly dysfunction" with "machine dysfunction" to support his view that "dysfunction", at least as used in medicine, is a factual notion. And he makes it clear that his motive for developing his argument in this way, is to attract to medicine generally, and in particular to psychiatry, the advantages of a properly scientific status. How far, then, does he succeed in this objective?

7. The basis of the distinction proposed by Boorse between "disease" and "illness" is examined further in Section III:4. But this apart, it is clearly a condition for the success of his programme that "dysfunction" itself, and in particular the notion of a "failure of natural function", should be value free. But this condition is not, self-evidently at least, satisfied. For, as we have seen, while "dysfunction" is indeed more overtly factual in certain contexts than in others, the notion, taking ordinary use as a whole, has evaluative as well as factual associations. At the very least, therefore, if Boorse's programme is to succeed, some explanation, or simply some justification, for relying on only one aspect of the sense of the term, must be provided. And no such provision is made. Indeed, while Boorse's main contention, taken as a whole, is that "disease" may be defined without introducing value terms, such terms continue to crop up even in his own statement of his views. At one point, for example, Boorse actually slips into defining "disease" itself by reference to "deficiencies in the functional efficiency of the body" (1975, p.59). And elsewhere (1976, p.71), the disease "neurosis" is defined as a subcategory of "disvalued" mental function. Boorse, therefore, although purporting to show

that the evaluative component of the meanings of "disease" and "illness", can and should be excluded (by reducing their technical use in medicine to that of "dysfunction"), nonetheless leaves evaluative flags firmly attached to his argument. These flags are largely obscured by his repetitive insistence that "dysfunction" of the kind with which he is concerned is value free; but they are there all the same.

8. Now, it could be, of course, that the persistence of value terms in the presentation of Boorse's views is the result merely of a stylistic habit with no logical significance. Equally, however, this persistence could itself be an indication that the evaluative side to the meaning of "dysfunction", however inapparent it may be in certain contexts, is nonetheless logically crucial. After all, these value terms persist not, as it were, by default, but against all efforts at eradication. And the factual criteria by which Boorse and others attempt to define "disease", seem so straightforward and self-evident, and therefore so readily deployed, that if such criteria were really sufficient logically, there would seem to be little temptation to lapse into evaluative language. Indeed, it is precisely where these factual criteria are attended to most directly, that value terms seem to reappear. Thus,

in the examples quoted from Boorse in the preceding paragraph, the term "deficiency" is introduced in his discussion of the observation that certain diseases may be statistically normal in any given population, so that what counts as a diminished capacity for survival and reproduction, and hence what counts as "disease", cannot be defined actuarially. And neurosis, as a "disvalued" mental function, occurs in a similar discussion of the same difficulty in respect of mental disease. These value terms therefore, seem to appear not by mistake, nor even as a convenient shorthand, but rather because what Boorse has to say cannot be said without them.

9. Prima facie, then, it seems likely that the persistence of value terms in discussions of this sort, may be symptomatic of the logical importance of the evaluative element in the meaning of "dysfunction", and hence perhaps of "disease" and "illness". It would seem, that is to say, that however prominent may be references to matters of fact in the ordinary use of these terms, expressions of value are actually entailed by them. And this conclusion, indeed, is consistent with one interpretation in the philosophical literature of the logic of value terms generally. Thus, Hare in particular has argued (e.g. in *The Language of Morals*, 1952, chs.5 and 6), that while there is a

descriptive element in the meaning of value terms, and while indeed it is these descriptions that operate as the (factual) criteria by which value judgements are made, the prescriptive element in the meaning of such terms is logically crucial also. Hence, any attempt to define a value term by reference only to the factual criteria for the value judgement that is expressed by it, must of necessity lose the commendatory or action-guiding property of the term. But it is this property that is essential to the ordinary use of value terms, specifically as value terms. Hence, if a value term is used as though it were equivalent in meaning to the factual criteria for its use, it will no longer be capable of doing the job that value terms in ordinary use are meant to do. In consequence therefore, if we try to use a value term defined in this way, we will find that we are unable to say the things that we would normally wish to say using that term. And this, it would seem, is precisely what has happened to Boorse; despite all his efforts to define "disease" by reference only to matters of fact, when he attempts to pursue his views in terms of his definition, value terms slip back in.

10. Boorse's argument, indeed, given this persistence of value terms, would seem to amount

not so much to the view that "disease" may be defined without introducing evaluations, but rather that the value judgement expressed by "disease" is entailed by certain facts (specifically, such facts as relate to the capacities of organisms for survival and for reproduction); given, that is to say, only that certain facts are true of a person, animal or plant, then, by definition, that person, animal or plant has a disease. Understood in this way then, Boorse would seem to be arguing for a naturalist or descriptivist interpretation of "disease" as a value term. And, as Hare (1952, 1972) has pointed out in respect of such interpretations generally, they are persuasive, if at all, only so long as our attention is confined to examples of value judgements, the factual criteria for which are not, or not credibly, disputed. In such examples, that is to say, it may seem that since we must agree that if certain descriptions apply then a given evaluation follows, the evaluation in question may be defined in terms of these descriptions. And indeed, in such cases, if there are difficulties or disagreements over the value judgements concerned, these will stem from the descriptive, and not from the evaluative part of their meaning; that is, from whether or not the descriptive criteria for the evaluation apply in any particular case, not from what those criteria

should be. And so, it will be the factual rather than the evaluative part of the meaning of such value terms that will be most prominent in ordinary use. But despite all this, the "must" involved in examples of this sort, is a contingent not a necessary "must". It so happens that, for certain value judgements, there are descriptive criteria to which everyone may feel compelled to agree. But the compulsion is, in Hare's phrase, a psychological not a logical compulsion. Or, as Warnock (1978) expressed the point in respect of moral evaluation, whatever descriptive criteria, X, are proposed, it is always logically possible to ask, "is X moral?" And since this question is not self-contradictory, X does not define moral.

11. The case, therefore, such as it is, for the definition of value terms by reference to matters of fact alone, rests on those instances of value judgements, the descriptive criteria for which happen to be very largely agreed. And so it is for the notion of "dysfunction", at least as this notion is used in respect of the body. Boorse, indeed, together with Scadding, (1959, 1963, 1967), Kendell (1975), and others, employs the expression "natural function" to embody the idea of some standard of normal function that is so undisputatious

as to provide a definition of normal against which abnormal function is to be measured. "Such-and-such must count as bodily dysfunction" we are obliged (psychologically) to say. And we would have to admit, in consequence, that whether or not a bodily part in any particular instance is functioning properly, is a question that is decided by reference only to the facts of the case. Scadding, who was concerned only with physical disease, deliberately held back from any further definition of "natural", the content of the notion being taken to be self-evident. But, for Boorse and Kendell, whose primary concerns were with psychological disease, some further specification of what was to count as "natural" seemed essential. Both authors recognised that the notion was capable of different interpretations, but both considered that the capacities for survival and reproduction, if not exhausting the functions that constitute "natural function", must at least be among them. And, no doubt, most people would agree that to survive and to reproduce are, on the whole, good things to do. But it does not follow from this that "dysfunction" means, inter alia, failure of survival and/or reproduction. Aside, that is, from any difficulties of specifying what kind or condition of survival, or how much reproduction, is good, it is not self-contradictory to deny that

survival and reproduction themselves are good. Such a denial would be unconventional and perhaps not fully credible, but it would not be self-contradictory. The fact therefore, that some condition of the body is constituted by or results in reduced longevity or fertility, does not in itself entail a negative evaluation, let alone the negative evaluation expressed by "dysfunction", and so, on Boorse's account, by "disease".

12. It would seem, therefore, that the notion of "dysfunction", even as this notion finds application in respect of bodily parts and organs, is irreducibly an evaluative notion. However prominent may be references to matters of fact in the ordinary use of the term, and however consistent may be the relationship between particular facts and the value judgement expressed by the term, any attempt to define "dysfunction" by reference to these descriptions alone, will exclude the prescriptive or commendatory part of its meaning. No set of facts, therefore, however clearly or completely described, will entail the value judgement that is expressed by "dysfunction". It is however, the uncontentiousness of at least certain of the factual criteria for the use of "dysfunction" in respect of the body, that explains both the prominence of factual considerations

in the use of the notion in this context, and the apparent persuasiveness of attempts to define the notion in terms of these criteria. Furthermore, what is suggested by the work of Hare, and others, about the ways in which the relative prominence of the descriptive and prescriptive elements in the meanings of value terms may vary, this conclusion is in principle fully consistent with the differences in different contexts, in the extent to which "dysfunction" is overtly an evaluative notion. It is clear, for example, in a general way (examined in more detail in Section IV), that the factual criteria for "dysfunction" in respect of mental processes are more contentious than those for bodily processes; so that, the more evaluative associations of "mental dysfunction" compared with "bodily dysfunction" in ordinary use, may be explained without introducing, or, as Szasz would have us do (para II:4;4), acquiescing in the suggestion that there is any qualitative logical difference between them.

13. The properties of the notion of "dysfunction" in ordinary use, therefore, including the prominence of references to matters of fact in the use of the term in certain contexts, are all fully consistent with the status of the term as a value term. That is to

say, once proper attention is paid to the properties of value terms generally, the status of "dysfunction" as to fact or value ceases to appear equivocal, the notion being straightforwardly evaluative in nature. But, it may now be objected, surely this conclusion could have been established without the lengthy argument of preceding sections. For this argument, indeed, in the present section has not as yet been referred to at all. Furthermore, the objection might continue, the argument of Sections II:2 and II:3 would seem to recapitulate in certain important respects, the arguments against naturalism in ethics as summarised in the present section. So that one or other line of argument, and presumably the longer of the two, would seem to be redundant. Thus, the earlier form of argument began, like naturalism in ethics, with examples of the notion that are uncontentious (viz., with examples of "mechanical dysfunction"); even in respect of these however, the sense of the notion could not be derived solely from a description of the properties of machines. This descriptive account, therefore, like descriptivist accounts of value terms, appeared to lack some logically essential element. Once this element was introduced however, (the notion of "purpose" in the case of "dysfunction") it became possible to draw the distinction between

"dysfunction" and "normal function", and the sense of the term, to this extent, was explained. The argument was then repeated for "bodily dysfunction", the main differences between the two uses of "dysfunction" being explained by a difference in the way in which purposes become ascribed respectively to machines and bodies; "purpose" therefore operating as an important determinant of the properties of "dysfunction" in ordinary use, just as, in the present section, the evaluative element in the meaning of the term has been shown to do.

14. The two forms of argument, therefore, that from the distinctions implied by "dysfunction" in ordinary use (Sections II:2, II:3), and that from the properties of "dysfunction" as a value term (Section II:4), are closely similar in certain respects. But these similarities, surely, do not imply that either form of argument is simply an empty repetition of the other. On the contrary, they complement each other in several ways. For example, where the argument of Sections II:2 and II:3 runs from the specific to the general, that of Section II:4 runs from the general to the specific. That is to say, where the former argument is by way of generalisation from the distinctions implied in ordinary use by "dysfunction" in reference specifically

to machines, the latter derives the properties of "dysfunction" as a particular value term, from those of value terms generally. Furthermore, the fact that the arguments are in this way complementary, would suggest that they share some point of common logical reference. And the most obvious candidate for this is the notion of "purpose". Indeed, "purpose" itself, from the test of non-contradiction, would seem to be a notion that implies evaluation. It would be, for example, self-contradictory to ascribe a given purpose, P, to someone, but to deny that P was in some sense positively evaluated by that person. Similarly, it would not make sense to ascribe purposes to the things that animals do, other than as those purposes were assumed to be in one way or another, good for them- if not as individuals, at least as individual species. The claim, for example, that the self-destructive behaviour of lemmings is purposeful, would imply that such behaviour is good for lemmings. And because it is hard to imagine in what way this could be so, their behaviour appears to be literally purposeless. Given the close link, therefore, between "purpose" and "value", our two forms of argument both show the crucial logical importance of the evaluative element in the meaning of "dysfunction".

15. However, if the two forms of argument are complementary, so far as the evaluative element in the meaning of "dysfunction" is concerned, the argument of Sections II:2 and II:3 offers an important strategic advantage. For, as we have seen (II:2), the kind of value judgement that is expressed by "dysfunction" is sharply restricted logically. But the argument from the properties of value terms generally to those specifically of "dysfunction", provides no obvious mechanism, other than plain special pleading, for demonstrating what is special about "dysfunction". Indeed, properly to restrict the evaluative element in the meaning of "dysfunction", this form of argument, from the general to the specific, would have to fall back on certain of the steps in the argument from the specific to the general. In order, that is, to exclude e.g. moral or aesthetic value, from what counts as a given motor car functioning well or badly, the argument would have to rely simply on noting that what counts as "dysfunction" is restricted by what is taken to be the function of a car; and this, in turn, on the way in which a car is taken to serve its particular purpose. The argument of Sections II:2 and II:3, however, in interpreting the distinctions implied by "dysfunction" in ordinary use, brings out directly, and without special pleading, the crucial logical

significance of "purpose" to the notion of "function" and so to that of "dysfunction"; and the further demonstration that the argument of Section II:4 provides, is merely that certain of the features of the earlier form of argument derive from the evaluative element in the meaning of "purpose" itself. Indeed, Hempel's observations (1965) of the logical impossibility of deriving the functions of biological systems from descriptions of the properties of such systems, looks to be simply a special case of the more general difficulty of deriving value from fact.

16. The form of argument of Sections II:2 and II:3, therefore, which, in effect, traces the logical origins of the distinctions implied by "dysfunction" in ordinary use, allows us to rely on the properties of value terms generally without the necessity for distinguishing among different kinds of value judgement. It is, then, to borrow from the terminology of psychiatric practice, a technique that is "problem orientated", restricting attention to the most immediately relevant features of the case. And indeed, as with problem orientated methods in psychiatry, this form of argument elicits these features accurately and in considerable detail. The importance of certain of these details (e.g. the distinction between "done by" and "done or happens to")

will become apparent in subsequent sections. There is however, one particular point that arises from the considerations of Section II:3, and that bears on the results of the present section, which point we will therefore consider briefly by way of conclusion.

17. In the present section, we have seen that attempts to exclude the evaluative element from the meanings of "disease" and "illness" by reducing them to "dysfunction", fail because "dysfunction" itself is a value term. Such attempts, as we have seen, are motivated by a desire to establish a value free basis for scientific medicine. However, the results of Section II:3 show that in relation to this objective, the exercise itself is superfluous. Thus, in Section II:3, the notion of "function" was shown to arise by a process of selection from among the ordinary properties of things, those that served most effectively the purposes of people (and of other living things). But it is just these "ordinary properties" that are investigated by science. Hence, scientific investigation could in principle proceed without introducing the notion of "function" at all; let alone raising questions of good and bad function. We are, in science, concerned with these questions, and hence with the functions of things (bodily or mechanical); but

because, to paraphrase, they matter to us, not because they have otherwise any special place in the world.

18. On this interpretation then, even in so far as "illness" and "disease" in technical contexts may be reduced to "dysfunction", there is neither motive nor justification for attempting to exclude the evaluative element from their meanings. And indeed, given that we have found this element to be logically crucial, we may suspect that such attempts have been not only unnecessary but misguided. For if an evaluative element is crucial to the meaning of "dysfunction", we may suspect that it is crucial also to the meanings of "disease" and "illness"; and hence that a clear recognition of this element will contribute to the interpretation of the conceptual difficulties with which we are primarily concerned in analysis. We will see in subsequent sections, the extent to which this is so.

II:5 IMPLICATIONS

1. We have, in the present section, examined the notion of "dysfunction", partly in its own right, and partly as a preliminary to examining the notions of "disease" and "illness". In this latter respect, we have established three important results: that a term may have largely factual connotations, and yet be a value term (II:4;10-12); that this constitutes no necessary impediment to the employment of such terms in science, the empirical investigations of which are, in effect, concerned with the phenomena that figure in the descriptive element in their meaning (II:3;4 and II:4;17); and that attempts in analysis to exclude the evaluative element from the meanings of these terms, may be misconceived, since this element may be crucial to the interpretation of their logical properties (II;3;6 and II:4;12-18).

2. Besides these results, however, we have established also the effectiveness of our "problem orientated" method of analysis - viz., close attention to the distinctions implied by the ordinary use of a term, followed by an attempt to trace the way in which these distinctions are drawn. By this method, in the present section, we have found the sense of "dysfunction" to be a good deal less self-evident

than we might have expected from the fact that the use of the term is largely uncontentious. We may anticipate then, as we anticipated on different grounds in Section I, that when we examine, in the next section, the sense of the equally uncontentious notion of "physical illness", this also will prove to be similarly obscure. And further that, if a problem orientated method of analysis has been helpful in interpreting the sense of "dysfunction", such a method will be essential when we come to examine the prima facie more complicated notions of "disease" and "illness".

III ILLNESS AND PHYSICAL ILLNESS

SUMMARY: The method of analysis and results of Section II are applied to "illness" and to "disease", interpretations of the ordinary use of these terms being developed from examples of physical illness and physical disease.

III:1 PHYSICAL ILLNESS AND DYSFUNCTION

1. The ordinary use of the terms "illness" and "disease" is in general more contentious in respect of mental conditions than in respect of physical conditions. This difference, as we saw in Section I, has led to the widespread assumption that "mental illness" is in some way logically inferior to "physical illness", which assumption has in turn influenced the form of argument that has been adopted generally in the literature. In Section I, we raised doubts of a rather general kind about this assumption, and these doubts, in Section II, have now been given more precise shape. For in Section II we found that the use of "dysfunction" in respect of objects is in general less contentious than its use in respect of bodily parts, not because the former has any logical priority, but because of certain differences in the ways in which purposes come to be ascribed to objects and to bodily parts

respectively. "Mechanical dysfunction", that is to say, we found in effect to be simply a particular, rather than a particularly logically sound case of "dysfunction".

2. Nonetheless, our initial choice, in Section II, of clear and uncontentious examples of "dysfunction", did lead directly to the logically crucial notion of "purpose"; and hence from the particular notion of "mechanical dysfunction" to that of "dysfunction" generally. We anticipated in Section I, that a similar process of generalisation would be necessary in interpreting the difficulties presented by "mental illness". Hence, it will be appropriate to begin our analyses of "disease" and "illness" with relatively uncontentious examples of their use in respect of physical conditions. Though in thus following convention, we do not of course admit the conventional prejudice in favour of "physical illness".

3. We will examine the notion of "illness" in the next section; that of "disease" in Section III:3; and the relationship between these two notions, and between both of them and "dysfunction", in Section III:4. Our analysis will begin with a simple comparison between "dysfunction" and "illness". In Section II:1 we noted that these notions are

closely related logically but not identical in meaning. Such a comparison therefore would seem to offer the most direct method for exposing the differences between them. The method of analysis adopted in Section II is in fact particularly well suited to extending the argument in this way. For if "dysfunction" and "illness" are different in certain respects, we should expect that these differences should be reflected in the distinctions that are implied by the ordinary use of the terms. Hence, having examined the distinctions implied by "dysfunction" in ordinary use, we may compare these with those implied by "illness", and with some reasonable expectation that the similarities and differences between these distinctions will prove to be logically significant.

III:2A ILLNESS CONSTITUTED BY MOVEMENT OR LACK
OF MOVEMENT

1. If the argument is to proceed by way of comparison, it is clear that those examples of illness that are likely to be most effective in revealing the essential logical differences between "illness" and "dysfunction", will be those that are most akin to the examples of dysfunction examined in Section II. To some extent, of course, whatever hints and clues are available, the initial selection of examples must be intuitive. For its final justification will consist in the extent to which these examples prove to be instructive. Among examples of illness, however, it is those that are constituted by movement or lack of movement that compare most directly with examples of bodily and machine dysfunction. It is therefore with examples of illness so constituted that we will begin our analysis of "illness", even though movement and lack of movement are perhaps less common constituents of illness than are phenomena such as pain. We return to examples of illness of this latter kind in Section III:2B.

2. In certain circumstances then, people are taken to be ill in virtue either of the movements

or of the lack of movement of their bodies. (In the remainder of this section the unqualified use of the term "movement" will be taken to include "lack of movement".) The jerking movements of chorea provide an example of the former; various kinds of paralysis examples of the latter. However, not all such movements are taken to be constitutive of illness; indeed, neither jerking nor keeping still is typically constitutive of illness at all. Furthermore, these two kinds of movement are not exhaustive of those that may be constitutive of "illness". We must ask then, as we asked in respect of "dysfunction" in Section II, what is involved in the ordinary distinction between movement that is taken to be constitutive of illness, and movement that is not.

3. When we raise the question in this way, certain negative answers are suggested immediately by the results of Section II. Thus, the distinction would seem not to rely on knowledge of underlying bodily causes (cf. II:2;3). For these causes may not in fact be known; and in any event, such a distinction would have to rely tautologically on a further distinction between pathological and non-pathological causes. Similarly, the distinction may not be effectively drawn in terms of "abnormality",

either statistical or ideal (cf. II:2;4-7). For neither of the kinds of movement we have illustrated is in itself unusual. And pathological movement (i.e. movement that is taken to be constitutive of illness) is not the only kind of negatively evaluated movement.

4. Besides these negative considerations however, the results of Section II suggest also a positive parallel between "illness" and "dysfunction". For both notions imply "something wrong" with their respective subjects (the former with persons, the latter with machines or bodily parts, II:1;4), and "something wrong" as distinct from things that are done or happen to them (II:3; 1). A person, for example, would not be taken to be paralysed if his arms and legs were merely restrained; nor would his movements, however jerky and uncontrolled, be taken to be pathological if they were caused by electric shocks. In this respect indeed, "illness" may actually be distinguished from such notions as "wound", and indeed from that of "damage" generally; which notions, as in the case also of machines, imply some more or less manifest harmful agency. Though we should, of course, add, as in Section II, the caveat that damage (which may be aesthetic rather than pathological anyway) may be a cause of illness (cf. II:2; 8).

5. To the extent of this distinction, therefore, the notion of "illness" in respect of people, is similar to the notion of "dysfunction" in respect of people's bodies or their machines. Both terms, that is to say, predicated of their respective subjects, imply a distinction between something wrong with that subject and something that is done or happens to them. But now, however, a difference between them becomes apparent. For "something wrong" with a machine or bodily part, was shown in Section II to be distinguished from things that are done or happen to them, as something that a machine or bodily part itself does or fails to do (II:3;1). And this distinction, indeed, proved to be crucial to the sense of "function" itself, within which "functioning properly" and "not functioning properly" were distinguished. But "something wrong" as constitutive of "illness", far from being distinguished as something a person does or fails to do, is actually distinguished from things they do or fail to do. A person would not be taken to be ill in virtue of their legs not moving if the person concerned was simply not moving them; or in virtue of their legs jerking if they were jerking them.

6. "Illness" and "dysfunction" therefore appear to be similar in respect of one aspect of this

distinction but different in respect of the other. On the one hand, both imply "something wrong", with a person or with a bodily part or machine respectively, as distinct from something that happens or is done to them. On the other hand, where "dysfunction" is distinguished, together with "function" generally, as something a bodily part or machine does or fails to do, "illness", at least as constituted by movement or lack of movement, is distinguished from things that people do or fail to do. As we anticipated in Section III:1, then, the distinctions that are implied by "dysfunction" and by "illness" respectively in ordinary use, are different. And the particular difference we have found reinforces our suggestion, in Section II;1, that the two terms are not equivalent in meaning. For if "dysfunction" is distinguished as, and "illness" from, something that is done, the substitution of one term for the other in an expression, must change the meaning of that expression. Indeed, to the extent of this difference, it would seem that the substitution of these terms should produce an expression of contrary meaning.

7. "Illness" and "dysfunction" however, are clearly neither equivalent nor contrary in meaning. The relationship between them is, no doubt,

a good deal more complex than either of these.

(We consider this relationship further in Section III:4.)

Our present purpose, however, is limited to interpreting the sense of "illness" by comparing it with "dysfunction".

And in this respect, the observations of the preceding three paragraphs suggest quite simply that the notion of "doing" may be as important logically to the sense of "illness" as, in Section II, we found it to be to the sense of "dysfunction". We have, however, from the kind of example we have considered thus far, only this rather general result. For more specific insights, therefore, we will turn now to examples of illness of a quite different kind.

8. In Section II:1, we noted that while "dysfunction" is used most commonly in respect of objects such as machines and bodily parts, there is a literal use of the term also in respect of people. This use, as we saw, arises in respect of social functions, so that where a person may properly be said to be functioning, and hence to be functioning well or badly, it is their work (as policemen, doctors, and the like) rather than their health, that is referred to. There may, of course, be various contingent relations between the two. It may be difficult, for example, for a policeman or doctor who is ill to function as he should. But the two are nonetheless in general logically quite distinct.

9. There are however certain examples of a particular kind of epileptic phenomenon, that of epileptic automatism or fugue, in which the two notions appear to be at least very closely related; and from which, therefore, since these are crucial or critical examples, we may hope to characterize more closely the differences between them. Patients suffering from this condition carry out more or less complex activities which occasionally include activities that are integral to their functions in society. Hughlings Jackson (Taylor, 1932) for example, reported, among other such cases, that of a doctor who made a correct diagnosis of pneumonia in the course of an epileptic fugue. Such cases of course, are not common; nor indeed, is the diagnosis as such, in any particular case, above reproach. But what is pertinent here is that it makes perfectly straightforward sense to describe the doctor (in Hughlings Jackson's case), both as functioning properly and as being ill in virtue of what he did. That is to say, despite "function" (in this case indeed, "normal function") being distinguished as something that is done, the ordinary description of the case is not self-contradictory.

10. Now, the first point that we may draw from this is that the sense of "do" that is implied by "dysfunction" must be different from that which

is material to the sense of "illness". For not only is the subject the same for each part of the description (viz., "the doctor is functioning"; and "the doctor is ill"), but both parts of the description refer to the same set of movements. Hence, if the sense of "do" were also the same in each case, our description of it would amount to saying both that the doctor is doing (qua function) something, and that the doctor is not doing (qua illness) the same thing. Which would be self-contradictory.

11. This kind of case, however, suggests also a second point, that the sense of "do" that is material to "illness" is that in which people typically are said to do things, viz., that sense of "do" which in Section II:3 we called "action". Thus, social functions are performed by a wide variety of things; besides the things that people do, by money, by universities, and so on. But in so far as they are served by the things that people do, then, since people's doings qua people are typically actions, they will tend to be served by people's actions. But this need not be so. At least certain functions, including those of the kind illustrated in the present case, could in principle be served equally well by a machine.

Hence, these functions could be served by a person doing things as a machine typically does things rather than as a person typically does things. And this would seem to be what is implied in cases of this sort; by the very label, "epileptic automatism"; but also by the fact that the epileptic would not normally be taken to be either morally or legally responsible for what he does in a fugue, precisely because his doings are taken not to be actions. Hence, while social functions may be served by people's actions, they are not necessarily so served. And what distinguishes, in the present case, the performance of a (normal) social function as illness, is that, in some logically important sense, what is done by the person concerned is not his action.

12. In this one unusual, but logically important, kind of case then, there would appear to be a conceptual link between "illness" and "action". But there are indications that this link is of wider significance. First, illness generally is an excuse, moral and legal; and it would seem to owe its status in this respect in some way to a connection with "action". Flew (1973), for example, suggests that the connection may be made by way of the notion of "incapacity", though he does not elaborate on this. Secondly, it is this notion, of "incapacity", that

perhaps most accurately characterizes what is often the first subjective intimation of illness. And it is this experience which, in what Flew (1973) calls the "central case", viz., illness as applied to people, is the primary determinant of what counts as disease (we examine the logical priorities of these notions further in Section III:4). Indeed, in that the primary application of "illness" is in respect of people (II:1;4), it correlates in this respect with the attribution of "action"(II:3;3). And this correlation provides a third indication that the two notions are conceptually related. Which indication is supported by the wider correlation that exists between the ordinary use of "disease" (viz., in respect of living things generally, II:1;4) and the attribution of "self-directed" purposeful activity (II:3;3), of which activity "action" is a particular kind.

13. Now it is clear that one way in which this line of argument might be pursued would be by turning to the philosophy of action. And indeed, our observation, in Section II:3, of the crucial logical significance of the notion of "purpose" to the sense in which functional objects "do" things, and our present suggestion that the notions of "doing", "action", and the like are

important conceptually to the sense of "illness", indicate the relevance of this subject. In the present study, however, as we argued in Section I, our primary strategy must be to rely, in the first instance at least, on careful attention to the features of our ordinary conceptual scheme. And indeed, if we now follow this strategy, we find that there is a property of our ordinary notion of "action" which is directly relevant to our understanding of its relationship to "illness", and which, indeed, is not remarked in the literature. In the remainder of this section we will examine this property of "action" mainly in connection with "illness" constituted by movement. Its wider significance will become apparent in subsequent sections.

14. In Section II:3, we illustrated the ordinary notion of "action" by the distinction between what is involved in the claim that "I moved my leg" and the claim that "my leg moved". This, as we observed, is a conventional way of introducing the distinction between "action" and other terms that may be used to describe the things that people do. And it is conventional also to observe that there is no hard and fast dividing line between that which is taken to be done by way of action and that which is not. The latter perhaps would include

breathing, blinking, and the like, which would seem to be in much the same category as, for example, digesting; while activities such as walking seem sometimes to be constitutive of actions and sometimes not. What is not commonly observed, however, is that an important determinant of this dividing line, is the difficulty with which what is done is done. That is to say, among those activities that may constitute actions, the probability that on any particular occasion they will be taken to do so, is governed partly by the difficulty with which they are done on that occasion. Or, to put the point differently, it is effort that seems to bring out the action in us. And this is so, both for our own experience of what we do as action, and as we attribute action to others. Walking against the wind, for example, is more likely to be taken as action than is walking as a stroll in the park; and even breathing and blinking may constitute actions where they are (partially or wholly) frustrated.

15. A further observation made in Section II:3 was that a central kind of action, so far at least as human activities are concerned, is intentional action. In respect of this kind of action, the effect of "difficulty" appears to derive from the fact that our expectations of what we can do, on any particular occasion, are always to some extent uncertain. If this were not so,

we would intend to do only those things which we could do. And an important source of this uncertainty about what we can do, is that the extent to which what we intend to do will be obstructed or opposed, is not something that we can accurately anticipate. It was, of course, just this obstruction and/or opposition that was implied in the examples given at the end of the preceding paragraph. It would seem then, that whatever else may be involved in an exhaustive characterization of the sense of "action", our ordinary conception of the notion is given a particular edge in those circumstances in which what we expect to do is done only with difficulty or not at all; and that these circumstances are commonly those in which what we do is obstructed or opposed.

16. That this conclusion may have some relevance to our present study, will be apparent if we now translate it into the kind of terminology adopted in preceding sections: viz., what is done (or attempted) by someone is most likely to be experienced (or attributed to them) as an intentional action (or attempted action) where it is (in part or completely) either obstructed by things that happen to them, or opposed by things that are done to them.

"Action", then, gains an important part of what we may call its existential shape, in contrast to things that are done or happen to us. But if this is so, we may now ask how we would experience a failure to

do (or not do, cf., para 1 above) what we intend to do in the apparent absence of obstruction or opposition. The "shape" of such a "doing", surely, would be equivocal. On the one hand, it would not be experienced as something that is done or happens to us; indeed, in that it is our own body that is moving or not moving, what is done, in the sense that objects do things, is done by us (cf., the epilepsy case discussed above, para 9). On the other hand, though, what is done is not what we intended to do, and hence would not be experienced as intentional action.

17. "Action failure", then, in the absence of apparent cause, would be experienced neither as something that is done or happens to us nor as something that we do (qua action). The features of this experience, therefore, correlate with those of the distinctions which, in paragraphs 4-6 above, we suggested were implied by the ordinary use of "illness". And this correlation, together with the other indications that we have noted of a link between "illness" and "action", suggests that the notion of "illness", at least of the sort we have considered in the present section, may perhaps have its origin in this experience. This is not to say, of course, that we have this experience "before our minds" every time we use the word "illness". For clearly, this is not so; the notion has, as it were, developed

somewhat from this putative original experience. And we will see in Sections III:3 and III:4, some of the ways in which this development has taken place. But, if we have read the correlation aright, it does suggest that at least some of the logical properties of "illness" may be explicable in terms of its link with "action". And conversely, if such explanations are forthcoming, they, in turn, will support the interpretation of "illness" that is suggested by it. We will examine one such property, therefore, in conclusion.

18. The property in question is that of "illness" as a value term. In Section II:2, we suggested that "dysfunction", "disease" and "illness" are all properly to be regarded as value terms; though they are not sufficiently characterised in this way since they express a particular kind of value, specifically not moral or aesthetic value. We examined "dysfunction" as a value term in Section II:4, the results of which section may now be seen to be closely similar in certain important respects to those of the present section. Thus, in Section II:4, the evaluative element in the meaning of "dysfunction" was shown to be logically crucial, by the failure of "descriptivist" analyses of the term; and early in the present section we made the same point in regard to "illness" (albeit briefly; we use this argument again at greater length in subsequent sections). Then, in Section II:4, the particular kind of

negative evaluation that is expressed by "dysfunction" was identified, by drawing on the results of Section II:3, with that which is implied by "purpose". And the obvious implication of this move for the present section is that the evaluative element in the meaning of "illness" may be identified similarly with that which is implied by "intention". But this would follow directly if the notion of "illness" is derived, as we have suggested, from the experience of "action failure". For "intention", like "purpose" generally (II:3;3), implies positive value (II:4;14); hence, a failure to do what is intended will necessarily be evaluated negatively.

19. Our interpretation of "illness", then, in terms of "action failure", offers some insight into one important logical property of the term. To this extent, therefore, the interpretation itself is provided some support. We shall find, indeed, in subsequent sections, that the interpretation is capable of taking us much further. And in particular, in Section IV, that its three related elements ("value", "intention" and "action") are crucial to our understanding of the properties of "mental illness", both as these are similar to, and as they differ from, those of "physical illness". Our interpretation, however, has been developed in the present section from examples of illness constituted by movement. In respect of such examples, the link between "illness"

and "action" may have some prima facie plausibility because the movements of our bodies are so self-evidently involved in our actions. Illnesses of this sort, however, as we noted at the beginning of this section, are far from typical. Before therefore, we explore further the implications of our interpretation, we must first see how far it may be extended to those more commonplace examples of illness that are constituted by phenomena such as pain.

III:2B ILLNESS CONSTITUTED BY SENSATION OR LACK
OF SENSATION

1. At the end of the preceding section we suggested that the interpretation of "illness" developed therein in terms of "action", might be considered to owe its plausibility largely to the fact that we considered examples only of illness constituted by bodily movement or lack of movement. And such examples of illness, as we observed, are far from typical. It would not be unreasonable, therefore, to suspect that our interpretation was partial and incomplete. In the present section then, we will examine the extension of our interpretation to those more commonplace constituents of illness, feelings and sensations, and in particular to the sensation of pain. As in previous sections, we will assume throughout our ordinary understanding of these notions, including the ordinary assumption that pain is indeed properly regarded as a sensation. This assumption, though, has no special significance for the argument. The issues raised in the present section derive rather from the ways in which the notion of "pain" differs from that of "movement" in our ordinary conception of it.

2. The suspicion from which we must begin then, is that our interpretation of "illness" in terms of

"action" relied in some special way on the kind of examples of illness that we have considered thus far. And we do not, of course, have far to look for what might be "special" about these examples. For the movements of people's bodies, it might be said, are involved obviously enough in their actions - many actions are indeed described, partly at least, in terms of these movements - but their feelings and sensations surely are not. Feelings and sensations, after all, are not ordinarily things that people "do" at all. Perception, perhaps, may have some of the properties of action: the exhortation, for example, to look harder, is similar in its properties to the exhortation to run harder; people are blamed for failing to notice traffic lights; and so on. But illnesses constituted by movement, although not rare, are not the most common kinds of illness. And in any event, such examples leave the difficulty raised by illnesses constituted by sensations such as pain quite untouched. For in whatever ways "perception" may be like movement in its relations to "action", in these ways also it differs from feelings and sensations. Perception, that is to say, in these respects, is something that people do. And it is in that feelings and sensations, despite being the more typical constituents of illness, ordinarily are not things that people do, that they seem to raise a central difficulty for our interpretation of the sense of "illness".

3. This difficulty, however, is not confined to the present interpretation of "illness", but arises equally for any interpretation that relies directly or indirectly on things "doing" things. Thus, the choice of examples of "illness" in Section III:2A, was dictated by their similarity to the examples of "dysfunction" interpreted in Section II. The argument, it will be recalled, was to proceed from the sense of "dysfunction" to that of "illness", initially by way of a direct comparison between them. Hence, it was considered that the examples of illness that would bring out by contrast the pertinent differences between "illness" and "dysfunction", would be those that were most like the examples of "dysfunction" considered in Section II. But the examples of "dysfunction" considered in Section II, were chosen precisely because they were typical or central cases of "dysfunction". Hence, the considerations that led in Section III:2A to the choice of unusual examples of illness being used for an initial comparison between "dysfunction" and "illness", themselves show that typical examples of dysfunction are different from the most common types of illness. The notion of "dysfunction", indeed, although, in its most general interpretation, derived from the properties of things, is intimately connected with movement, whether of machines or bodily parts, whether of limbs, gasses, fluids, or whatever. "Dysfunction", whether of machines or bodies, may result in feelings and sensations but it is not ordinarily constituted by feelings and sensations. "Illness", on the other hand,

commonly, and even centrally, is so constituted. This difference indeed provides yet further evidence that the notions of "illness" and "dysfunction" are not equivalent in meaning. And, while the fact that "illness" is typically constituted by feelings and sensations may appear to be a difficulty for the present interpretation of "illness", it must present an insuperable objection to all those interpretations of "illness" that rely on "illness" and "dysfunction" being equivalent in meaning. In relation to this difficulty, then, the present interpretation offers at least the face value advantage of avoiding this equivalence.

4. The difficulties, however, that are raised by examples of illness constituted by feelings and sensations, are not all one sided. That is to say, while it may, certainly, appear to be difficult to subsume examples of illness so constituted to interpretations of the sense of "illness" that rely on a mechanical analogy (whether, as so commonly in the literature, by way of identification, or, as in the present study, by way of contrast), the sense of "illness" even in such typical examples of the notion, is by no means self-evident. Such examples, simply in being typical, are commonplace and familiar; and they are commonly uncontentious. In consequence, therefore, they go largely unremarked. But to be unremarked is not necessarily to be unremarkable. And indeed, if we step aside from the familiarity of the experience of "feeling ill", it becomes clear that it is by no means obvious what distinguishes feelings and

sensations that are experienced as illness, from feelings and sensations that are not so experienced.

5. But this, it may be said, is surely to press the point too far. For the difficulty here would seem to be merely one of, as it were, descriptive complexity, rather than one that involves any obscurity of principle. The difficulty, that is to say, is merely that there is such a wide variety of sensations and feelings that may be constitutive of illness. And hence, while it may not be immediately obvious how these are to be distinguished in general from feelings and sensations that are not constitutive of illness, nonetheless an effective strategy for drawing the distinction would seem to be obvious enough. For in principle, surely, all that is required is a catalogue describing the feelings and sensations involved: a somewhat lengthy catalogue no doubt, but a catalogue plain and simple nonetheless. However, such a catalogue, to be complete, would have to include certain feelings and sensations as constitutive of illness, that were identical, in so far as a description of the feelings and sensations themselves are concerned, with feelings and sensations that were not constitutive of illness. The pain of neuralgia, for example, may be identical with electrically induced nerve pain: the former constitutes something wrong, the latter does not. Hence, even if the strategy of cataloguing could be shown to be an effective method for distinguishing the sense of "illness", the content of such a catalogue would have to go beyond a mere description, however

complex and complete, of the feelings and sensations involved.

6. Something more, however, than a merely descriptive catalogue of feelings and sensations, is required to distinguish the sense of "illness". That this should be so, of course, given that "illness" is a value term, is anticipated in a general way, by the results of preceding sections. These results, however, provide also more specific insights. Thus, in Section III:2A, certain distinctions were noted to be implied by the ordinary use of "illness" constituted by movement or lack of movement; similar distinctions were examined in Section II, in relation to "dysfunction"; and the sense both of "illness" as constituted by movement or lack of movement, and of "dysfunction", has been interpreted by tracing the logical origins of these distinctions. It now seems, however, from the example of neuralgia noted in the preceding paragraph, that part at least of what would be required to define illness as constituted by feelings and sensations, may be understood in terms of these same distinctions. For the distinction between neuralgia and electrically induced nerve pain, would seem to be the distinction between something wrong with someone, and something that is done or happens to them. And the same or a similar distinction is implied for other feelings and sensations; we speak, for example, of being "numb with cold". Caveats like those noted in preceding sections apply, of course. "Illness" may result from the repeated experience of pain, whether pain as illness

or otherwise; painful illnesses may be known to be caused by external agencies; and so on. The logical significance of these cause-effect relationships, in particular whether pain as illness, and even "illness" generally, may be defined in terms of underlying bodily lesions, viz., bodily dysfunction, will be examined further in the next section. It does seem, however, that the experience of pain as illness, involves at least one of the distinctions implied by illness constituted by movement or lack of movement.

7. It is not however, this particular distinction that is involved crucially in the difficulty that examples of illness constituted by feelings and sensations appears to raise for the interpretation of the sense of "illness" developed in Section III:2A. It is not, that is to say, the distinction between "something wrong" with someone and things that happen or are done to them that is problematic; rather, it is the distinction between "something wrong" with someone, and things that they do (III:2A;5).

The example of neuralgia however, does suggest a way in which this difficulty might be resolved. For while one might withdraw from a painful electric shock, and, unrestrained, normally one would do so, from neuralgia there is no withdrawal. One may get treatment, or it may go away, but one cannot withdraw as such. Pain then, although not something one does, is nonetheless something that normally one does something about. And it is, furthermore, something that one does

something in particular about, viz., withdraw. It is, after all, by prompting withdrawal that pain serves its normal function of protecting the body from damage. Withdrawal then, is an important component of the normal experience of pain.

8. Against the relevance of this observation, however, it may be objected that, while withdrawal is undoubtedly what one normally does about pain, such withdrawal is normally reflex, and not something that one does intentionally. Therefore, the sense in which withdrawal is something that one does, is not that sense of "do" in which people typically do things, viz., the sense of "action"; and it was the sense specifically of "action" that was crucial to the interpretation of "illness" developed in Section III:2A. However, as noted in para III:2A;14, there is no hard and fast or fixed boundary between activities that are intentional and those that are not. Some activities that are normally reflex may be experienced as intentional actions; and this is most likely to be so where they are made difficult in some way. And so it is for withdrawal from pain. Like walking against the wind (III:2A;14), it is where withdrawal or attempted withdrawal is opposed or obstructed that it is most likely to be experienced as an intentional action.

9. The rest of the interpretation now follows straightforwardly enough. If withdrawal is

a normal component of the experience of pain, and if withdrawal from pain is experienced as an action in circumstances in which it is frustrated, in part or completely, then the experience of withdrawal from pain as an action, will be gained, like that of action generally (III:2A;15), in contrast to withdrawal that is frustrated by some external agency. The existential status then, of a failure to withdraw from pain in the absence of some frustrating cause, will be equivocal. As with movement generally (III:2A;16), if one's intention to withdraw is frustrated in the absence of frustrating causes, the experience will be neither that of one's own action, nor that of something that is done or happens to one. As far as pain is concerned then, the properties of the experience of being unable to withdraw in the absence of apparent frustrating causes, correlates with the distinctions that are implied by illness generally in ordinary use. And this correlation, clearly, is identical with that developed in the preceding section for illness constituted by movement or lack of movement (III:2A;17).

10. Among feelings and sensations generally, pain is perhaps the most common and hence the most typical constituent of illness. The objection to the interpretation of "illness" developed in the preceding section then, that it was based on untypical examples of illness, now loses some of its force.

A similar interpretation, however, may be extended to other kinds of feeling and sensation; for feelings and sensations generally, or those at least that may be constitutive of illness, are associated, like pain, with activities that may become intentional. Nausea, for example, with the elimination or avoidance of potentially toxic gastric contents; dizziness with balance, and so on. That such phenomena may be experienced as things that we do something about (i.e., rather than as constitutive of illness) would be perhaps more obvious in the circumstances of a primitive way of life. The protected environment in which we live has largely removed the occasions for such experience. But interpretations along the lines of that developed for pain should present no difficulties of principle.

11. Our interpretation of "illness", then, so far as physical illness is concerned, has achieved a fair degree of generality. The distinctions implied by the ordinary use of the term, in respect now of a wide variety of examples, have been shown to correspond with the properties of the experience of action failure in the apparent absence of frustrating causes. The extent of this correlation thus suggests that the origin of the notion of "illness" may indeed be identified in this experience. We have, then,

strengthened the expectation raised at the end of the preceding section, that this identification may provide for an effective interpretation of the sense of "illness", and hence of its logical properties generally in ordinary use. And if the sense of "illness" interpreted in this way would seem not to be immediately self-evident, this, in itself, should arouse no resistance; for it was, after all, anticipated at the end of Section I that this would be so.

SECTION III:3 PHYSICAL DISEASE

1. In preceding sections, attention has been drawn to a variety of differences in the ordinary use of the terms "illness", "disease" and "dysfunction". Certain of these differences were noted in a preliminary way in Section II:1, the conclusion being drawn that these terms, although closely related logically, could not be regarded as equivalent in meaning. In subsequent sections, certain further differences, mainly between "illness" and "dysfunction", have been examined in more detail. These further differences have served to confirm and to underline the results of Section II:1, so far as "illness" and "dysfunction" are concerned, these terms being shown to be clearly, and in several different respects, distinct in meaning. However, if the ordinary use of "disease" is examined in similar detail, a less determinate picture emerges. For, as we shall see, "disease" appears in certain contexts and in certain respects to resemble "illness", in other contexts and in other respects to resemble "dysfunction", and in yet others to stand somewhere between the two. The ordinary use of "disease", that is to say, shows it to be related conceptually to both notions. In the present section, both aspects of this relationship will be examined, together with the ways in which it is reflected in, and has influenced, the literature. In the next section, the properties

of "disease" in ordinary use will be considered in relation to the interpretations of "illness" and of "dysfunction" proposed in earlier sections.

2. One aspect then, of the ordinary use of "disease" is its close identification with "illness". This identification indeed, as we suggested in Section II:1, is perhaps the most prominent characteristic of the ordinary use of the term; "disease" and "illness" occurring in close contextual proximity; the terms being, at the least, closely related in meaning, and in many contexts used actually as synonyms (the expression "some terrible illness", for example, might equally be rendered "some terrible disease"); and "illness", in the Shorter Oxford English Dictionary, being defined, *inter alia*, in terms of "disease". Moreover, this ordinary identification of "disease" and "illness" has been carried over into the literature, in which, as we noted also in Section II:1, the differences between the terms have been until recently almost entirely ignored. Indeed, a large majority of those authors referred to in Section II:1, whether opponents or proponents of the concept of "mental illness", use "disease" and "illness" as though they were fully interchangeable. As Farrell (1979) remarks, even so meticulous an author as Kendell (1975) seems to take it for granted that "illness" and "disease" are synonyms; Kendell writes, for example, "...we have first to decide on an adequate definition of illness; to decide if you like what is the

defining characteristic....of disease" (p.306).

3. So "disease" and "illness" are, in Hare's (1978) phrase, "near synonyms", but they are only near synonyms. For the terms, although in certain contexts genuinely synonymous, are not in general logically interchangeable. It is perhaps, the recognition of this, together with a growing awareness of the possible practical implications of acknowledging and making explicit the distinction between "illness" and "disease", that has led to the appearance in recent years of a number of papers drawing attention to the differences between them. These differences, in those contexts in which "disease" is distinct from "illness", are many, and the recent literature is correspondingly diverse in emphasis. Furthermore, the fact that "disease" itself seems capable of appearing in different guises (e.g. both like and unlike "illness", and in other varieties as described below), makes the sense of the term peculiarly difficult to distinguish. There are however, as we noted in Section II;1, certain contexts in ordinary use in which "disease" and "illness" are not merely distinguished but contrasted. The most common of these contexts are those in which some morbid bodily change is identifiable in someone who, at the time, has no actual symptoms. The example, given in II:1;5, was of the diabetic

patient whose condition was fully controlled on insulin; a second example would be the patient with an asymptomatic lesion detected by a routine screening procedure. In cases of this sort, the patient would be said to have a "disease", in that he has some morbid bodily change; but he would not normally be said to be ill, for he has no actual symptoms.

4. It is this kind of case that appears to be implied, more or less directly, in the recent literature on the differences between "illness" and "disease". Thus, Barondess (1979) writes... "disease may be viewed as a biologic event characterised by anatomic, physiologic or biochemical changes, or by some mixture of these...illness, on the other hand, is not a biologic but a human event...an array of discomforts and psychosocial dislocations..." Similarly, Taylor (1979) writes of "disease" as ... "discernable as physical reality... as tangible evidence to the specially tuned senses of the physician". It involves "specific changes in the structure of tissues"; it is "amoral... independent from the testimony of the patient... and it carries medicine into bioscience and the basic sciences." However, while "disease is about things... illness is about experiences... (it is) a commentary... a rule-governed role which will be evaluated and and judged... (and may result in) exemption from...

obligations". In an earlier paper, Feinstein (1967) sums up the distinction along similar lines, suggesting that disease is described in... "morphologic, chemical, microbiologic, physiologic and other impersonal terms...(whereas)... illness consists of clinical phenomena, the host's subjective sensations..". Feinstein's distinction is employed by Kraupl-Taylor (1979), and essentially similar views are expressed by Lipkin (1964), Smith (1975), Wing (1973), and others. "Disease" therefore, in so far as it is distinct from "illness", is taken to be a matter of bodily change, it is objective, precise and factual, and a conventional object of scientific enquiry. "Illness" on the other hand, has more to do with feelings and sensations, being a subjective notion, of personal significance, but vague, and determined largely by individual and social values. It is "illness" that is the personal, while "disease" is the impersonal notion; "illness" is for patients, "disease" is for doctors and scientists.

5. Recent authors then, although differing somewhat in emphasis, provide a more or less consistent description of the differences between "illness" and "disease", differences that correspond with, and are most clearly illustrated by, certain contexts in ordinary use in which the terms may be used contrastingly. Contexts of this sort,

however, take us further still. For they suggest that the relationship between "disease" and "illness" should be understood as one of cause and effect - some bodily change (= disease) causing symptoms (= illness). And it is indeed this causal account of the relationship between "disease" and "illness" that is adopted most widely in the recent literature. There are, as with the descriptive part of this literature, differences of emphasis. For some, Taylor (1979), for example, the relationship, although clearly implied, is not made explicit; Taylor describes "illness" as being "referrable to disease". For others, disease, understood as morbid bodily change, is acknowledged to be one, but only one among other possible causes of illness; Barondess (1979) distinguishes "biologic events" as diseases both from "stressful life events" and from "reactions to perceived threats"; all three being regarded as "environmental stimuli" for illness. It is recognised by some authors that certain diseases, such as migraine and epilepsy, are defined in terms of symptoms and signs, and without reference to morbid bodily changes as causes of those symptoms and signs. And this indeed, as we shall see subsequently, is an observation of crucial conceptual significance. But in the literature, the sense of "disease" in these, as it were, phenomenological cases, is taken to be secondary to the causal sense of the term.

Wing (1973), Wing et al., (1974) and Kraupl-Taylor (1979), for example, all regard diseases defined symptomatically, as implying and as provisional upon, eventual discovery of bodily causes. While Taylor (1979) refers to the use of "disease" in reference to a patient's symptoms, as merely "careless". Throughout these variations therefore, the clear theme is that "disease", in an important and possibly primary sense, should be understood in terms of the bodily causes of the symptoms by which "illness" is constituted.

6. With this account of "disease", in those contexts in which the term is distinct from "illness", we are drawn also to the second aspect of the ordinary use of the term, that in which it is identified with "dysfunction". The differences in the properties of "illness" and "disease" described in paragraph 4 above, are clearly reminiscent of those noted earlier, in Section III:2, between "illness" and "dysfunction" - "illness" being subjective, vague and evaluative, while "disease", like "dysfunction", is objective, precise and factual. And the supposed cause-effect relationship between them (paragraph 5), may seem to point directly to the notion of "dysfunction", and "bodily dysfunction" in particular, as crucial to the sense of "disease". For, as many authors have observed (both those who distinguish between

"illness" and "disease" and those who do not - e.g. Kraupl-Taylor (1979) and Kendell (1975) respectively), while diseases, even as defined causally, are defined in terms of a wide variety of different kinds of cause, it would seem that it is only in so far as these causes are taken to constitute, or to be mediated by, some disturbance of function, that they count as diseases at all. We distinguish, for example, in respect of known pathogens such as the typhoid bacillus, between carrier states on the one hand, in which the organism, though present and unwelcome, is asymptomatic; and, on the other hand, diseases, in which the organism produces some disturbance of function, and in which the person infected by it, is, or may become, ill. Certainly, the use of "disease" may sometimes imply no more than that some bodily part or system is not functioning as it should. Some references to "renal disease" or to "liver disease", for example, or, more specifically, to "obstructive airways disease" or "diabetes", may be of this sort. And in the Shorter Oxford English Dictionary, while "illness" is defined in terms of disease (II:1;1), "disease", but not "illness", is defined in terms of "dysfunction", and "bodily dysfunction" at that. Just as, therefore, in certain contexts in ordinary use, "disease" may appear as a synonym for "illness", so, in others it may appear as a synonym for "dysfunction";

and this despite "illness" and "dysfunction" themselves not being logically interchangeable.

7. This second aspect of the sense of "disease", that in which it is identified with "dysfunction", is perhaps a less prominent feature of the ordinary use of the term than that in which it is identified with "illness". In the literature, however, as we saw in Section II:1, it is a good deal more prominent: in that, not only have "illness" and "disease" been conflated, but the sense of "disease/illness" has been interpreted actually in terms of "dysfunction" of one sort or another. And even in the more recent literature, in which "illness" and "disease" are distinguished, this interpretation, though less universally accepted, persists. Barondess (1979) for example, describes "disease" as "a disruption in the structure and/or function of a bodily part or system"; and Wing has repeatedly emphasised the central importance of the idea of "abnormal function" (e.g. 1973, 1978). But it is, after all, not surprising that this should be so. For the literature, both early and recent, is largely either by doctors themselves, or by those whose interest is primarily in the activities of doctors. And as we noted in paragraph 3 above, it is "disease-as-distinct-from-illness", and therefore

in that aspect of the use of the term in which it approximates in sense to "dysfunction", that is the more "technical" side to the ordinary use of "disease". This use of the term indeed, corresponds with the "disease" or (disparagingly by the critics of psychiatry) "medical " model of illness, the varieties of which span, like "disease-as-distinct-from-illness", from symptom clusters, through various causal classifications of disease, to detailed theories of bodily dysfunction (for review, see e.g. Macklin, 1973). The form that the literature has taken then, may be understood as a product not simply as suggested in Section II:1, of a failure to recognise or to acknowledge the evident differences in ordinary use between "illness", "disease" and "dysfunction", but rather of a perhaps too exclusive attention to the predominant use of these notions in medicine.

8. However, if the literature is to be understood in this way, as shaped by those aspects of ordinary use that are most prominent in medicine, this may seem not merely to explain but perhaps also to justify the form that it has taken. For "illness", "disease" and the like are, after all, principle concerns of doctors, and of doctors as experts. Hence, it could be argued, those aspects of the ordinary use of these notions that are most

prominent in the specialist discourse of doctors, are likely to be of some crucial conceptual importance also. At the very least then, the attention given in the literature to "disease", and in particular to "disease" as a causal notion, might be well directed. And furthermore, the definition of "disease" in terms of "dysfunction", might be considered to be stipulative rather than partial. After all, the argument might continue, medicine has been increasingly successful in recent years, and this success, we may suppose, is due in part at least to the "modern" concepts that are employed by doctors. These concepts however, for various, largely historical reasons, remain to some degree obscure. Hence, a prime objective of analysis must be to make explicit, and so fully effective, the conceptual structure of modern medicine, whatever variations on this structure may still persist in other, non-technical, contexts. Something along these lines, indeed, was foreshadowed in Section II:4, in which it was suggested that the strongly factual associations of "dysfunction", compared with "illness", provided a clear motive for what was there described as the reductionist tendency in the literature; the attempted reduction of "illness/disease" to "dysfunction" appearing to appropriate to medicine the advantages of a fully scientific status. In Section II:4, this reduction

was shown to fail in its objective because "dysfunction" itself is a value term. Nonetheless, it could now be argued, the definition of "disease" in terms of "dysfunction" might still be justified, at least for technical or specialist use, by its less overtly evaluative connotations. "Disease" that is to say, at least as a technical notion, is already used in this way, and to good effect; why not, then, as in the literature, make this use explicit and determinate?

9. Despite its apparent attractions, however, this stipulative form of argument is not widely represented in the literature. With certain exceptions (notably Boorse, 1975 and 1976, as discussed below), we are in effect asked to accept not, as it were, by consensus, that "disease" as a causal notion, and specifically as defined in terms of "dysfunction", should be adopted as the prescribed sense of the term, at least in technical use; but rather that this simply is the sense of the term, properly understood. There are however, certain clear indications that the former, more moderate claim, if not overtly adopted by a majority of authors, would nonetheless provide an acceptable interpretation of their views. A common device, for example, in presenting "disease" as "dysfunction", is to anticipate the definition itself with an historical review of the changes that have taken

place in the classification of diseases. Scadding (1967), Kendell (1975), Campbell et al., (1979) and Kraupl-Taylor (1979), in the pro-psychiatry lobby, together with Szasz (1961) and many others among the anti-psychiatrists, all remind us that the emergence of scientific medicine has been paralleled, and to an extent even constituted by, a distinctive historical shift in disease classification. A clear progression is identified, away from the definition of disease categories in terms of subjective symptoms and signs, through classifications based on pathology (bodily changes together with presumed aetiological agents of various types), to detailed knowledge of the functions of bodily systems and how these may become disturbed. A somewhat similar picture is drawn by certain authors, for example by Wing et al., (1974) and Roth (1976), of the process of medical diagnosis; which, in effect, recapitulates the historical development of the subject. With such images in mind then, it is easy enough to accept the broad implication that it is "disease", and "disease-as-dysfunction" in particular, that is, as it were, the conceptual corner-stone of modern medicine. It is, as Wing (1978) expresses it, "well-developed" disease theories that rely on knowledge of functions. And, in consequence, analyses which make this explicit, could be taken to be refining scientific from pre-scientific ideas, the clear from the unclear,

the more from the less useful.

10. This difference in emphasis, however, in the extent to which the stipulative nature of many of the arguments presented in the literature is openly acknowledged, although in itself a small difference, has had important consequences. For it has led to a failure properly to recognise the different purposes for which different models or interpretations of "disease" have been advanced; and this in turn has played a large part in generating the contention by which so much of the literature is characterised. Clearly, a proposal that is expressly labelled "stipulative", a proposal in the form "disease should be understood as so-and-so", will tend to make explicit, and so to attract discussion of, both the purpose of the stipulation and the extent to which that purpose is served. Whereas, in the form "disease" is so-and-so", arguments for and against the proposal, although necessarily concerned with its merits, may not distinguish adequately the purposes against which, in any particular case, merit itself should be measured. And so it is in the literature. Indeed, the many definitions of "disease" (even the varieties of the "medical model" itself) are presented, by and large, as mutually exclusive alternatives. An argument for one formulation is taken to be an argument against others. The success of

behavioural techniques, for example, in respect of certain disorders, is portrayed by behavioural psychologists both as vindicating their own (symptomatic) model of disease, and as condemning other (causal) models; and in this condemnation is included not only the medical model (viz., conceived in terms of bodily causes), but also all the varieties of psychodynamic model (viz., conceived in terms of unconscious mental causes) (e.g. Ullman and Krasner, 1966). Similarly, the salutary attention to social and ethical aspects of mental illness, that is generated by what Macklin (1973) calls the "social-scientific model of disease", is taken by its proponents as evidence against all those models that emphasise other aspects of mental disorder, including its causes and symptoms (e.g. Scheff, 1967). The actual practice of psychiatry, whether by psychiatrists, psychologists or social workers, is of course a good deal more eclectic than the literature might suggest. But in the presentation of the different concepts of disease that are appropriate to different disciplines, there is surely, in the present state of our knowledge, scope for less polemic and more syncretism.

11. But besides this failure adequately to distinguish different kinds of practical consideration, there has also been a failure, to some extent, to distinguish practical considerations generally from those that are conceptual or analytical

in nature. In particular, there has been a tendency, in arguing for or against any given model or interpretation of "disease", to confuse considerations that relate to the consequences of adopting the model in practice, with those that relate to the extent to which the interpretation clarifies the concept of "disease" itself. Attention has, however, been drawn to the importance of this distinction by certain authors. Walker (1968), for example, has indicated that definitions of "disease" that are recognised to be tautological (II:1;2), may nonetheless be appropriate for certain legislative purposes. Similarly, Macklin (1973) has argued, mainly in criticism of Szasz's views, that however unpalatable may be the practical effects of adopting a particular interpretation of "disease", these effects do not in themselves indicate that the interpretation is unsound. However, while the two kinds of consideration, practical and conceptual, are distinct, and while a failure to distinguish them is a further source of unnecessary contention in the literature, the two nonetheless are interdependent. For, as we saw in Section I, it is difficulties which, although conceptual in origin, have arisen in clinical practice, that have led to the present reappraisal of the received conceptual structure of medicine. And indeed, the mushrooming of alternative models of "disease", and the necessity for different models, even for obviously defective

models, for different practical purposes, are evidence of our continuing revisionary needs. Hence, although the difficulties that are presented by the language of medicine may not be limited to those that are of immediate practical consequence, difficulties of this sort must be of central interest in analysis. The first test, then, of any proposed interpretation of "disease", remains the extent to which it clarifies the concept of "disease", essentially as embodied in ordinary use; but the final test will be the extent to which such clarification contributes to the solution of those difficulties in the practice of medicine that showed the need for analysis in the first place.

12. How well then, does the "medical model" of "disease" measure up? For as we have seen in preceding sections, as a comprehensive account of the conceptual structure of medicine generally, it is deficient in several important respects. And indeed, so far even as problems of practice are concerned, it is no panacea. The large volume of objections to the model in psychiatry is perhaps sufficient evidence of this - and doubts have increasingly been raised about it even in physical medicine; doubts, for example, both about the priority of causal over symptomatic senses of "disease" (e.g. in diagnosis, Wing et al., 1974, and

in computer models of diagnosis, Engel and Davis, 1963, Scadding, 1967), and about the priority of the concept of "disease" itself over that of "illness" (e.g. in clinical practice, Smith, 1975, and in medical education, Taylor, 1979). But for all this, it might still be argued that the model should be adopted as the best available; and if "best" now means "best for resolving those problems of practice that are conceptual in nature or origin", this stipulative claim would seem to be subject in principle to definite, if quantitative, assessment. However, precisely because the purpose that the model is intended to serve tends to be left implicit, such assessment, for a large majority of presentations, would necessarily be hypothetical. There are, however, a minority of exceptions to this; Lewis (1953), Flew (1973), and Boorse (1975, 1976), for example, all discuss essentially "medical models" of "disease" and in application specifically to conceptual difficulties in clinical practice. Among these, however, only Boorse combines this openly stipulative approach, with serious and detailed attention to the other principle aspects of the use of "disease", that in which it approximates in sense to "illness". It is, therefore, with Boorse's account that we will conclude this section.

13. Most of what Boorse has to say about the

conceptual structure of medicine is set out in his 1975 paper. In his 1976 paper, he clarifies his account in certain respects, but is occupied mainly with a defence of psychoanalytic theory as the proper foundation for psychiatry, in so far as it is distinguishable from physical medicine. Boorse begins his account (1975, p.49) with an introductory section in which he describes the kind of problem with which he is concerned. He notes that there has been an increasing tendency in recent years "to debate social issues in psychiatric terms"... to prefer "medicine over morals". These "social issues" include "criminal responsibility, sexual deviance, feminism, and a host of others..." All then, matters of immediate practical concern. But the debate, he believes, "continues to be impeded" by a difficulty that is essentially conceptual,... "by a fundamental misunderstanding of the concept of health". Hence, while Boorse sets out to resolve a conceptual misunderstanding, it is with the contribution of this misunderstanding to certain practical problems that he is mainly concerned. Following the criteria suggested in paragraph 11 above, therefore, his analysis, whatever may be said for or against it otherwise, may appropriately be judged by the extent to which it contributes to resolving these practical difficulties.

14. Boorse returns to this question, to the contribution made by his analysis to practical issues, in the concluding section of his 1975 paper. In the first two-thirds of the paper, however, together with parts of the 1976 paper, he develops the analysis itself in detail. In effect, he brings together, and to a large extent makes explicit, the moves and assumptions which have been illustrated from the literature generally in the present section (though not always in the same order). Thus, his first point (1975, p.49), is that an analysis of "health" must distinguish between "disease" and "illness". He recognises (1975, p.50, p.62), as we recognised in paragraph 2 above, that "disease" elsewhere, both in the literature and colloquially, may be used in the sense in which he uses "illness". However, he proposes to "adhere to the technical usage of 'disease'" (1975, p.50), that which allows the attribution of "disease" in certain circumstances even in the absence of "illness" (1975, p.56 - c.f. paragraph 3). Boorse clarifies the distinction between "disease" and "illness" at various points in his two papers, essentially along the lines suggested in the present section in paragraph 4: "disease" is the "theoretical", "illness" the "practical" notion (1975, p.50), "disease" is "continuous with theory in biology and the other natural sciences" and is "value free" (1975, p.53; similarly, 1976, p.63); "illness" is a ... "mere sub-class" of "disease"... with certain

"normative features" (1975, p.56). The causal account (paragraph 5 above) of the relationship between "disease" and "illness", although not emphasised by Boorse, is evident in his description of these normative features. An "illness", he says, "must be... a reasonably serious disease with incapacitating effects that make it undesirable" (1975, p.56). And central to this causal sense of "disease", as we saw in paragraph 6, is the notion of "dysfunction". For, as Boorse puts it, even though in technical use, viz., as "found in textbooks of medical theory" (1975, p.50), diseases are defined in many different ways ... "the single unifying property ... appears to be ... that they interfere with one or more functions typically performed within members of the species" (1975, p.58).

15. All the principle components of the "medical model" of "disease" are then identifiable in Boorse's views. Indeed, in his 1976 paper, Boorse himself describes his analysis in this way (p.62). However, as Boorse's early reference to "illness" as a "mere subclass of disease" warns us (1975, p.56), in his adoption of the medical model, he adopts also the prejudices that this model tends to carry with it. He takes "disease", analysed as a causal notion and specifically in terms of "dysfunction", to be the key to the conceptual structure of modern

medicine. "Illness" is important, but only in the ... "institutions of medical practice" (1975, p.56). Certainly, Boorse would acknowledge, the terms "illness" and "disease" are used differently elsewhere. In particular, "illness" may originally, before the development of modern medical theory, have been used without implying "dysfunction" at all, referring perhaps to suffering and incapacity with some presumed supernatural cause (1976, p.76). But, he argues, as others have argued less openly elsewhere (see paragraph 9 above), this is a "primitive notion"... which, "with the rise of empirical thinking" ... has been ... "replaced by the idea of internal malfunction". And to seek to return, as he claims "contemporary psychiatry" seeks to return, to "calling people ill ... solely on the grounds of emotional turmoil or social maladjustment" ... is to "revert to archaic usage". Such usage, he says, is "two thousand years too late", and, in ignoring the development of medicine in the interim, "culminating in the functional conception of disease", it invites "unbearable cognitive strain". No wonder then, "the opacity of current controversies over mental health".

16. Boorse then, argues stipulatively. He recognises that his analysis is by no means exhaustive of the conceptual structure of medicine -

but he claims that it represents this structure in its most successful form, viz., in modern physical medicine. Hence, he may reasonably expect that his target problems, identified at the start of his 1975 paper as conceptual difficulties in or arising from psychological medicine, should be resolved, or at least diminished, by the application of his analysis to them. And since, as we have suggested, this constitutes a test of his analysis, we must now examine how far these expectations are fulfilled.

17. The first thing we find when we move with Boorse, in the third part of his 1975 paper, from physical medicine to psychological medicine, is a parallel move that is something of a surprise. Thus far, in that part of his paper which is primarily analytical, Boorse has been occupied more with "disease" than with "illness" - an emphasis that is clearly consistent with his view that it is "disease" which is the key notion in medicine. But now, when he comes to apply the results of his analysis to the problems presented by psychological medicine, the emphasis is reversed. It is "illness" that occupies him, almost to the exclusion of "disease". The relative proportions are striking. In the first part of his paper, approximately nine pages are devoted to "physical disease" and only two pages to "physical illness"; in the second part, four pages are concerned with "mental

illness", only one paragraph being allocated to "mental disease".

18. Now it may seem that this change in emphasis is easily enough explained. For Boorse's target problems are, after all, practical problems, and, on his own interpretation, "illness" is at least as important as "disease" in the conceptual structure of medicine as a practical discipline (e.g. 1975, p.55). Hence, it could be said, since these problems have arisen in, or are related to, the practice of psychological medicine, it is at least as likely that their origin is to be found in the concept of "mental illness" as in that of "mental disease". Indeed, in the one paragraph that is devoted to "disease" in the third part of his 1975 paper, Boorse asks us in effect simply to assume that "mental disease" is on a par logically with "physical disease", so that we may see how far the problems presented by "mental illness" may be understood in terms of his derivation of "physical illness" from "physical disease". Boorse's attention to "mental illness" therefore would seem to be well directed. And all would indeed be well, if the derivation of "mental illness" from "mental disease" could proceed conveniently in the way that Boorse suggests "physical illness" is to be derived from "physical disease". But as

Boorse himself freely admits (1975, p.62), it cannot. Each of the three normative criteria that he suggests for "illness" as a subclass of "disease" in physical medicine, present difficulties when applied to psychological medicine. For our present purpose, we need not examine these difficulties in detail - Boorse indeed does not appear to intend that we should do so - but we must consider the implication for his analysis of the plain fact that he is unable to move effectively from "physical illness" and "physical disease", to their mental counterparts.

19. On Boorse's account, "illness" is a derivative notion. Whether or not someone is ill (which is essentially the question around which his target problems revolve), depends first on whether they have a disease (viz., on whether or not their bodily or mental functions are in order), and only second on whether or not those normative features that, on his account, characterise a disease as an illness, are present as well. His difficulty then in moving from "mental disease" to "mental illness", would seem to be capable of three possible, though not mutually exclusive, interpretations. The first is that the notion of "mental illness" itself is defective conceptually. But this, in the absence of some more specific account

of its supposed defectiveness, would be merely question begging; and in any event it would not be very plausible given that Boorse has asked us to assume that "mental disease" is as sound a notion as "physical disease". The second interpretation is that the normative criteria by which Boorse distinguishes "illness", may have been wrongly identified. But these criteria (that "illness" is "undesirable" for the person who is ill; that it is a "title to special treatment"; and that it is "a valid excuse for normally criticizable behaviour", 1975, p.61), are not, so far as they go, contentious. It could be argued perhaps, that "illness" is incompletely characterised in this way; or that "disease" might be characterised similarly; but as characteristics of "illness" as such, they are hardly in dispute. Which leaves the third possible interpretation, that Boorse's assumption that "mental disease" may be modelled straightforwardly on his interpretation of "physical disease", is, after all, unjustified. And this in turn, leads back to the supposition that his assumption may be unjustified precisely because his analysis of "physical disease", and hence that of "physical illness" also, is mistaken.

20. This last interpretation of the failure of Boorse's analysis, which is perhaps *prima facie* the least unlikely of the three that we have considered, is further supported by a particular feature of the difficulties that he encounters. For these

difficulties tend to point, as it were, backwards from "mental illness" to "mental disease"; and in particular to the possibility that "mental disease", and hence also "physical disease", are not "value free" notions at all. He finds, for example (pgs. 62 & 63), that because homosexuality is defined by what someone "wants", and because "want" is a "normative" notion, the possibility arises under his analysis that homosexuality may be an illness but not a disease - which, given his derivation of "illness" as a subclass of "disease", is a result that contradicts the analysis itself. Similarly, a difficulty about "neurosis" (pgs. 64 & 65), obliges him either to give up his value free definition of "disease", or to abandon one of his constraints on the sense of "illness". This tendency, furthermore, consistently with the present analysis, points even more specifically to the kind of value that is implied in "illness" and "disease" being that which is implied in "action". For Boorse explains the status of "illness" as an excuse, in terms of the distinction between "function" and "action"; but when (pgs. 65 & 66) he attempts to apply this explanation to "mental illness" (which is at least as self-evidently an excuse as "physical illness", see IV:4), he finds that he cannot do so.

21. Boorse's account therefore, fails even if we regard it as a stipulative account of the notions of "disease" and "illness". And the particular way in which it fails directs us firmly back to the conceptual importance of the evaluative part of the meanings of these terms. This result is clearly anticipated in Section I, in which it was suggested that the difficulties presented by "mental illness" should prompt a more thorough reappraisal of our common understanding of the notion of "physical illness". And indeed, in so far as this "common understanding" has in the present section been identified with the "medical model" of "disease", the increasing prominence of conceptual difficulties in psychiatry in recent years (I;4), may now be understood as a product of a progressive failure of the "medical model" to meet the demands of modern clinical practice. Hence, all that Boorse and others who have relied on the "medical model" have done, is to repeat the historical process by which conceptual difficulties became substantive difficulties in medicine in the first place. Boorse's account makes this particularly clear, but this is a tribute to the particular candour of his style. We suggested in paragraph 8 above, that those less candid accounts in the literature, in which "illness/disease" is reduced to "dysfunction", relied on that aspect of the ordinary

use of "disease" in which it approximates in sense to "dysfunction". We may now add that these accounts rely also on the other aspect of the use of "disease", that in which it approximates in sense to "illness", for the covert introduction of the logically crucial evaluative element in the meaning of the term. We will examine in the next section the results of making this element explicit.

SECTION III:4 ILLNESS, DISEASE AND EVALUATION

1. It will by now be clear that the emphasis in the present study has shifted progressively away from that which has become conventional in the literature. In Section I, from "mental illness" and "mental disease" to "physical illness" and "physical disease"; then, in Section II, from the factual to the evaluative part of the meanings of these notions; and now, in the present section, from "disease" to "illness". Indeed, even our early and detailed attention to the notion of "dysfunction", in Section II, which superficially may have seemed reminiscent of the literature, far from providing, by way of identification, an interpretation of the sense of "disease", anticipated, by way of contrast, the analysis of "illness" developed in Section III:2.

2. These changes of emphasis have been prompted by mainly negative considerations; by the failure of the literature itself, and by the form that failure has taken. For, as we saw in some detail in Section III:3, while the conventional emphasis in the literature corresponds with those features of the conceptual structure of medicine that are most prominent in modern clinical practice, the analyses supplied by this literature fail to

resolve those specifically conceptual difficulties of clinical practice which gave rise to the need for analysis in the first place. By this test, then, (the "final" test as it was called in Section III:3), such analyses fail. However, the "first" test of analysis, which was mentioned, but not employed, in Section III:3, is one of consistency; of the extent to which an analysis is consistent with and explains the features of ordinary use generally, within which the particular difficulties of clinical practice themselves are set. And by this latter test, it could be argued, the conventional literature fares better. For just as the emphasis in this literature mirrors ordinary use, at least in technical and professional contexts, so, by the same token, the changes of emphasis in the present study represent a departure from it. There is, therefore, a clear positive obligation on us to explain the relative prominence of the different parts of the conceptual structure of modern medicine, those, as it were, large-scale, quantitative features of ordinary use, which, in more conventional approaches to the subject, are taken for granted. The present study has, of course, already performed reasonably well on this test of consistency, in respect of the notions of "dysfunction" and of "illness" considered separately in Sections II and III:2 respectively. It is, however, "disease" that is the more prominent notion in

technical use, and it is therefore with the analysis of this notion that our further obligation will be met.

3. "Disease", as we saw in Section III:3, is an equivocal notion, bridging "illness" on the one hand with "dysfunction" on the other, attracting the properties of both, in proportion as it approximates in sense to either extreme. However, the analyses of "disease" in the current literature, as we found, derived from attention not only to "disease" as distinct from "illness", but to "disease" in that aspect of the use of the term in which it approximates in sense to "dysfunction"; this use of "disease", as a causal notion with mainly factual connotations, being that use towards which medical practice itself moves, both historically and in diagnosis. The first step, therefore, in the present study, in interpreting the properties of "disease", must be to introduce a further, though perhaps less radical, change of emphasis. For if the direction of attention in the literature has proved unprofitable, we may hope for more advantage by attending, initially at least, to "disease" in the less prominent aspect of its sense, that in which it approximates to "illness".

4. The closest approximation of "disease" to "illness", is that use of the term in which it

describes the features of "illness" itself. This "symptomatic" sense of "disease" was illustrated by migraine and epilepsy in Section III:3. So close indeed, is this sense of "disease" to "illness", that commonly in ordinary use, it may not be clear which notion is implied. In saying that someone has migraine, for example, the force of what is said may be mainly that they are ill (e.g. in excusing absence from work), or that they have a disease (viz., migraine; e.g. as in making a diagnosis), or some combination of these. "Disease" as a causal notion is, of course, similarly indeterminate in use, though to a lesser extent. However, just as the causal sense of "disease" may be fully distinguished from "illness" in circumstances in which the terms are used contrastingly (III:3;3), so also for the symptomatic sense of "disease". Just as, that is to say, the patient with an early asymptomatic lesion, or with a disease such as diabetes, which may be controlled but not cured, may be said to have a disease even though they are, at the time, perfectly well, so also for conditions such as migraine and epilepsy. Nor does this contrasting use of the descriptive sense of "disease" rely on the covert introduction of the causal sense of the term; for the causes of migraine and epilepsy are unknown (though predisposing factors are recognised); and while some underlying

disturbance of bodily function may be presupposed, this presupposition, being general to scientific medicine as a whole, would apply indifferently to "illness" as to "disease". It is true that the symptomatic and the causal senses of "disease" are alike in that both are dispositional notions. It is indeed, this property that allows either to be used in contrast to "illness". But the causal sense of "disease" is dispositional in so far as the notion of "cause" itself is dispositional; in so far, that is, as it expresses, in Ayer's (1976) phrase, a "generalisation of tendency": whereas, "disease" in the symptomatic sense of the term, is dispositional only where the features by which it is constituted themselves include a disposition to relapse.

5. In ordinary use therefore, although "disease" moves often uncertainly among different implications, a sense of the term in which it describes the features of a particular kind of "illness" is clearly distinguishable, both from other senses of "disease", and from "illness" itself. And for this sense of the term, albeit a minority sense (in physical medicine at least) the relationship of "disease" to "illness" is readily derived. Thus, in Section III:2, "illness" was analysed as a value term, the evaluative part

of its meaning having its origin in the notion of "action failure". However, value terms, as we saw in Section II:4, besides having an evaluative or prescriptive element in their meaning, have also a factual or descriptive element. This descriptive element, furthermore, is constitutive of the criteria for the value judgement expressed by such terms. Hence the descriptive element in the meaning of the value term "illness", is immediately identifiable with the symptoms that constitute illness; with those bodily movements or sensations (III:2A, III:2B, respectively) in virtue of which someone is taken to be ill. Now, it is logically possible that in every illness the symptoms were unique, but in practice illnesses tend to be largely stereotyped in the form that they take. Hence illnesses may be grouped symptomatically, according to particular descriptive criteria for the value judgement which "illness" expresses. And with these symptomatic groupings, we have arrived at "disease" in the "symptomatic" sense of the term. Hence, the "symptomatic" sense of "disease" is a direct consequence of the evaluative nature of "illness", given the contingent regularities of what counts as illness.

6. The extent to which "illness" and "disease" are overtly evaluative notions in ordinary

use, now follows directly from their relationship as defined above. For, a necessary precondition for illnesses to be differentiated into groups according to the descriptive criteria for "illness" (viz., symptomatically), is that there should be a degree of agreement as to these criteria. But as we discussed in detail in Section II:4, where there is a good measure of agreement as to the criteria for the use of a value term, the evaluative part of its meaning may become ordinarily less prominent, while the factual part becomes more so. And so it is with "illness" and "disease"; in proportion as diseases are differentiated from illness, so the factual criteria for "illness" become more prominent, while the evaluation that is expressed by it becomes less prominent. So much so in fact, that, as with value terms generally (II:4), the use of "disease" may by convention come to refer only to the descriptions (viz., the symptoms) by which it is constituted. And hence, definitions of "disease" in the literature, particularly those proposed by medical scientists, will tend to be definitions of "conditions" rather than of conditions as diseases. Wing's (1973) definition of "disease" for example, excluding tautological (*) terms, would do as well for pregnancy as for diabetes - viz., a "limited syndrome that can be reliably recognised... (and in respect of which)

a) plausible guesses can be made about aetiology, pathophysiology, and underlying processes of normal functioning, b) the most effective use of pharmacological and social treatments will depend on a proper diagnosis of the disease, and c) the diagnosis implies a prognosis that can be fairly accurately made...". And indeed, as we noted in Section II:4, a proper recognition of the status of "disease" as a value term, leaves the scientific usefulness of the notion intact, since this is mediated by the factual part of its meaning. "Disease", however, even defined in this way (conventionally by reference to matters of fact), remains, in its logical origins at least, an evaluative notion. We return to the conceptual importance of this in Section IV.

7. The difference then, in ordinary use, in the relative prominence of the factual and the evaluative parts of the meanings of "disease" and "illness", is explained straightforwardly as a consequence of a well recognised logical property of value terms generally. Value terms, however, have other well recognised properties, which explain, with almost equal directness, certain other differences between "disease" and "illness". Thus, as emotivist theories of value terms have emphasised, the point of expressing an evaluation

differs in important respects from the point of referring to matters of fact (e.g. Stevenson, 1945; Ayer, 1936). Where a factual expression is intended typically to change what we know, an expression of value is intended typically either to evince or to evoke a feeling, attitude, or emotion, or sometimes to provoke a response. Hence, if "disease" and "illness" differ broadly as references to the factual criteria for a value term differ from expressions of value, we should expect similar differences in the point with which they are used. We should expect, that is, "illness" to be used more to evince or to evoke concern, to say, in effect, "something is wrong!" and "disease" to be used as in diagnosis in reference to what is wrong. Hence, as we saw in Section III:3, "illness" has the more personal, "disease" the more technical connotations; "illness" is broadly for patients, "disease" for doctors. Similarly, "illness" is more for people rather than for animals and plants (II:1;4), because it is primarily for people that we feel concern that something is wrong; "disease" (what is wrong), is more for animals and plants, except in respect of cases such as domestic animals and plants (II:1;4) for which our concerns may be like those concerns that typically we have for people.

8. Somewhat similar considerations go some way towards explaining a group of closely related differences between "illness" and "disease" in their respective associations in ordinary use: viz., "illness" being thought of as subjective, vague, and constituted mainly by feelings and sensations, while "disease" is objective, precise and a matter of bodily changes (III:3;4). Thus, feelings and sensations, being typically the most immediate components of the experience of "illness" (III:2B), necessarily figure prominently in the concerns of someone who is ill, and so in the initial criteria for "illness". Such feelings and sensations, however, are often complex, and so will commonly be capable only of imprecise report. They are, furthermore, subjective, in the limited sense that we rely largely on self-report in deciding whether or not they are present, at least in someone else. These two properties, therefore, the difficulty of, and our reliance on, self-report, make for poor reliability between observers in the identification and description of feelings and sensations. But for diseases to be differentiated from illness, there must be, as we have seen, a degree of agreement in the criteria for illness. Disease categories, it is true, can be defined by unreliable criteria (viz., where it is, de facto, agreed that descriptions X,Y,Z constitute illness, but there is only

limited agreement as to whether X,Y,Z describe a particular patient - a situation familiar enough in psychiatry); but such categories, even as descriptive of illness, would have little utility. Feelings and sensations, after all, figure not at all in the disease categories applicable to animals; not because we take them to lack feelings and sensations presumably, but because their reports of their feelings and sensations are so rudimentary as to have virtually no discriminatory value. Hence, given a choice of criteria, by a kind of natural selection among the possible classifications of illness, there will be a tendency for disease categories to shift away from the subjective to the objective, from the vague to the precise, from feelings and sensations to observations of bodily change.

9. Thus far then, the properties of "disease" have been derived, with some success, but in respect only of the minority symptomatic sense of the term. With the introduction of the notion of utility, however, these derivations may be extended to "disease" generally. Thus, the symptomatic sense of "disease" has been shown to arise through the differentiation of illness into particular kinds of illness, by way of the descriptive criteria for "illness". And from among these criteria, as

differentia of "disease", there will be a tendency to select those that are most reliably identifiable. However, while the criteria for illness (the symptoms that constitute illness), supply the most immediate criteria for differentiating diseases, they are not the only possible criteria. Indeed, if "disease" is understood generally as "a particular kind of illness", there is in principle no limit to the ways in which illness might be differentiated into diseases (a point that has been made in the literature, e.g. Scadding, 1967). However, the differentia of illness that are adopted in practice, will be governed by the requirements of practice itself. These requirements will vary, but the requirements specifically of medical practice are primarily the prevention and/or cure of illness; or, in default of these, the prediction of course and outcome. The differentiation of illness by the symptoms of illness (generating the descriptive sense of "disease") provides for the latter, and, to the extent of ad hoc pragmatic rules of management, for the former. In respect of these requirements, however, the differentiation of illness by the causes of illness, will clearly have much greater utility. In consequence therefore, while descriptive classifications of illness, in providing circumscribed symptoms or clusters of symptoms, are often an essential first step towards knowledge of causes,

in proportion as knowledge of causes accumulates, symptomatic disease categories will tend to be displaced in favour of causal disease categories. Hence, therefore, the historical shift, in physical medicine, from the symptomatic to the causal sense of "disease" (III:2;9), and the particular prominence of the causal sense of "disease" in modern clinical practice (III:3;7). But the causal sense of "disease", despite its importance in modern medicine, has no special logical priority. Indeed, in so far as the differentia of illness, whether symptoms or causes, are alike in being descriptive of illness, the observations of paragraphs 6,7 and 8, although developed in respect of "disease" defined symptomatically, will apply, *mutatis mutandis*, to "disease" generally. We have therefore, derived explanations not only for the quantitative differences in ordinary use between the two principle senses of "disease" (symptomatic and causal), but also for the differences generally between "illness" and "disease" however defined.

10. There remains a further consideration. For "disease", as we noted at the beginning of Section III:3, is an equivocal notion bridging conceptually between "illness" and "dysfunction". And while the present section, in deriving "disease" from "illness", has supplied a detailed account

of the relationship of "disease" and "illness", it has had nothing to say about the relationship of "disease" and "dysfunction"; nor indeed of that between "dysfunction" and "illness". In one sense, these relationships are readily accommodated to the present analysis, for "dysfunction" (whether bodily or mental) as a cause of "illness", could be considered simply as one variety of the causal sense of "disease" - an important and prominent sense of "disease" in practice, but for practical not conceptual reasons. And this interpretation would have the advantage of placing an appropriate restriction on the kinds of "dysfunction" that are logically relevant to "illness", thus meeting Flew's (1973) objection to the dictionary definition of "disease" simply as "dysfunction" (II:1;4).

11. This however, would probably be an over simple interpretation of the relationship of "illness" and "dysfunction". For "dysfunction" surely has some closer logical link with "illness" than this would imply. Thus, where we have "well-developed" (Wing, 1978) theories of bodily function, "disease-as-dysfunction" may be clearly distinguishable as "a cause of illness". But in other circumstances, "dysfunction" and "illness" are much more closely intertwined. The experience of my leg failing to move, for example, may prompt

(as in III:2A;) the suggestion that "there is something wrong with me"; but it might also prompt the suggestion that "there is something wrong with my leg." In the former case, "I am ill"; in the latter "my leg is not working properly". This is not to say that "illness" and "dysfunction" are, after all, equivalent in meaning (c.f. II:1). But rather to indicate that there is some close logical link between them, and that this link is not to be explained exhaustively by way of that which is provided by the equivocal nature of "disease" in ordinary use.

12. Just how the link between "illness" and "dysfunction" is to be explained, is however less obvious. The observations of the preceding paragraph suggest that such an explanation may involve the relationship in our ordinary conceptual scheme between "body" and "person", between "my leg moving" and "me moving my leg". And the nature of this relationship is itself a matter of metaphysical speculation. We will not however, pursue this speculation other than to indicate that the present analysis, in identifying the notion of "action" as a possible logical progenitor both of "dysfunction" (II:3) and of "illness" (III:2A), may provide a basis for a more complete account of the relationship between these two notions.

And in this, it could perhaps contribute to our understanding of the wider metaphysical issue of the relationship between persons and their bodies generally.

13. This section, although concerned mainly with the prominent notion of "disease", has been a short section; consistently, it may be said, with the changes of emphasis from the conventional literature to which we drew attention in its opening paragraph. These changes of emphasis, however, could not now be considered to belie the importance of "disease", and of the causal sense of the term in particular, in modern clinical practice. For the length of the present section is a consequence only of the readiness with which the properties of "disease", and of its relationships to "illness" and "dysfunction", may be derived from the analysis developed at greater length in preceding sections. And by implication, therefore, our present brevity provides evidence for, rather than against, this analysis, and the changes of emphasis that it has entailed.

SECTION III:5 IMPLICATIONS

1. The present study differs from the conventional literature, not only in emphasis, in giving attention at least equally to "illness" as to "disease", but in the logical significance that it attaches to each. For where, in the literature, if "illness" is distinguished from "disease" at all, it is distinguished generally as a minor derivative notion, lacking interest in analysis equally as it lacks importance in clinical practice, in the present study, these relative priorities are reversed. It is "illness" that is the prior notion, "disease" the derivative, the properties of "disease", including its importance in clinical practice, being generated by the logical properties of "illness" itself.

2. The recognition of this reversed priority has required some effort of imagination, mainly to disentangle ourselves from the common preconceptions of medical practice. For, as we have seen (III:3), whatever may be true of ordinary use as a whole, in medicine, particularly in the more technical aspects of the subject, it is "disease" rather than "illness" that is the more prominent notion. Nonetheless, once recognised, even in medicine, the logical priority of "illness" has considerable

prima facie credibility, notwithstanding the practical importance of "disease". After all, in the terminology of Section III:4, that "something is wrong!" must precede asking "what is wrong?" let alone doing anything about it. And indeed, though modern medicine is much preoccupied with "disease", it is with the experience of "illness" that, historically and in day-to-day practice, it has its origins.

3. The priority afforded "illness" in the present study therefore, is not so discordant with ordinary use as the prominence of "disease" in clinical practice may at first have suggested. For this prominence reflects the practical rather than the conceptual significance of "disease" in medicine. But surely, it might now be argued, it is precisely because the contingencies of practice are largely practical, that all this attention to "illness", however well justified in principle, is misplaced. And, "illness" being of logical rather than practical importance in medicine, the results of the present study, although providing a more comprehensive interpretation of the conceptual structure of the subject than has hitherto been possible, are of theoretical interest only.

4. We have, however, been concerned thus far mainly with physical medicine; and while it is true that in physical medicine the contingencies of practice are mainly practical, in psychological medicine they are conceptual also. It was, of course, this difference between the two disciplines that made it appropriate, in analysing "illness" and "disease", to start with examples of these notions drawn from physical medicine (III:1), even though the analysis itself was prompted by, and is directed ultimately towards, the difficulties presented by them in psychological medicine. In psychological medicine, then, we are de facto concerned, even as practitioners, with conceptual as well as with practical issues. And indeed, in regard to these issues, when we move in analysis from physical medicine to psychological medicine, we find that our present emphasis on "illness", far from requiring any special justification, offers an immediate strategic advantage. For in psychological medicine, the relative prominence of "disease" over "illness" is a good deal less self-evident than in physical medicine, in many contexts "illness" being actually the more prominent notion. Certainly, the problem around which much of the literature revolves, is referred to conventionally as the "problem of mental illness", not the "problem of mental disease". And this conventional reference, as we shall see in

Section IV, identifies accurately, though in the main inadvertently, the source of those conceptual difficulties in the practice of psychological medicine with which we are principally concerned in analysis. At the very least, therefore, our careful attention to "illness" should pay dividends when we come to consider these difficulties in the next section.

5. So our attention to "illness" in the present study is fully justified in a general way, if not by the logical importance of the notion in medicine as a whole, at least by its practical significance in psychological medicine. In this latter respect, however, our conclusion that "illness" is not only more important conceptually in medicine than is generally recognised, but actually prior to "disease" logically, offers a particular lesson. Thus, it is evident that, if "disease" is indeed a derivative of "illness", rather than "illness" being a derivative of "disease", attempts to resolve the conceptual difficulties presented by the notion of "mental illness" that rely on reducing "mental illness" to "mental disease", must fail. But this, in effect, is the strategy that is dictated by the "medical model". Which model, as we have seen, is widely adopted, explicitly or implicitly, in the literature (III:3;7-9).

Equally, however, against the opponents of the "disease model", the failure of this reductionist strategy, in itself provides no indication that the notion of "mental illness" is logically unsound. For "illness", being logically the prior notion, should not be reducible to "disease" at all. The failure of the literature generally, therefore, not only points us away from the assumptions and strategies upon which it relies (I:9), it points us directly towards the reversed lineage of "illness" and "disease" suggested in the present study. And the lesson for analysis, therefore, is that, if we are to make sense of the difficulties presented by the notion of "mental illness" in the practice of medicine, it will be by way of an interpretation of the notion of "illness" itself in its own right, rather than by way of a premature attempt to reduce "illness" to "disease".

6. It is, of course, just such an interpretation, of "illness" in its own right, that has been derived in respect of "physical illness" in the present section. Now, this exercise, as an interpretation of ordinary use, does not presuppose the logical soundness of any particular example of the use of the notion, least of all of those examples distinguished collectively as mental illness. It turns out, however, that there is a particular feature of the

notion of "illness" as instantiated by physical illness, which, if proper attention is paid to the notion in its own right, itself facilitates the move in analysis from "physical illness" to "mental illness". Thus, "physical illness", as we saw in Section III:2, may be constituted by bodily movement (or lack of movement) and/or by bodily feelings and sensations (or the absence of these). And our analysis, indeed, was directed at some length (III:2B) towards accommodating this feature of ordinary use. But bodily feelings and sensations (such as pain), would ordinarily be taken to be mental phenomena not physical phenomena. Hence, illnesses which are ordinarily distinguished as physical illnesses are constituted typically by phenomena which are ordinarily distinguished as mental phenomena.

7. This observation raises questions about the ordinary distinction between "physical illness" and "mental illness" (a point that has been noted in the literature, e.g. by Boorse, 1976, Macklin, 1973); as, indeed, it raises questions about the ordinary distinction between the notions of "physical" and "mental" themselves. And certainly, the distinction, such as it is, between "physical illness" and "mental illness" is a good deal less categorical in ordinary use than it is normally taken to be in

the literature (Flew, 1973, Kenny, 1969). But the significance of the observation itself, for the move in analysis from "physical illness" to "mental illness", is quite straightforward. For it is clear that if "physical illness" is constituted typically by mental phenomena, then, whatever difficulties may be presented by "mental illness", these difficulties do not derive simply from "mental illness" being constituted by mental phenomena; by particular kinds of mental phenomena, perhaps, but not by mental phenomena as such. And, by the same token, any interpretation of "illness" that accommodates fully the features of the notion as instantiated by physical illness, is equipped in principle to proceed by way of generalisation to those examples of the notion that are distinguished ordinarily as mental illness. In the present section then, as a direct consequence of attending to "illness" in its own right, we have satisfied the requirement that was settled at the end of Section I, for the move in analysis from "physical illness" to "mental illness". It is to "mental illness" therefore that we may now turn.

IV: ILLNESS AND MENTAL ILLNESS

SUMMARY: The interpretation of "illness" and "disease" developed in Section III from examples of physical illness and disease, is generalised to examples of mental illness and disease, explaining both the similarities and the differences between these two kinds of condition .

IV:1 MENTAL ILLNESS AND PHYSICAL ILLNESS

1. There are many differences between physical medicine and psychological medicine, but the main procedures of clinical practice, what doctors actually do, are closely similar in both disciplines. Uncontentiously so, in fact; for this self-evident similarity is assumed in the literature, and is the origin of, the highly contentious question whether what doctors do is equally well advised in both disciplines. Hence, in moving in analysis from physical medicine to psychological medicine, while no part of the conceptual structure of either discipline may be assumed as common ground, the practical procedures they share, provide a link between them.

2. Among these procedures, diagnosis and treatment are perhaps most characteristic of the

things doctors do. These, indeed, are closely related both as practical procedures and logically. For where, in medicine, the normal medical response to something being wrong, is to diagnose what is wrong (III:4;7), this response, as we have seen (III:4;9), is not neutral with regard to the facts, but directed mainly towards doing something about what is wrong, viz., to treatment. This feature of diagnosis, as against its straightforwardly classificatory function, has been emphasised in the literature (e.g. Campbell, 1977; Dudley, 1977). In this context, however, "wrong" must be understood to mean "wrong-as-illness" ("illness" here being used generically); for otherwise, diagnosis and treatment, although characteristic of what doctors do, are not specifically medical procedures, being performed generally in respect of things wrong by mechanics and by bank managers, for example, as well as by doctors. It is true, of course, that doctors may be employed other than in the diagnosis and treatment of illness; in athletics, for example, or in cosmetics; even, indeed, for personal or political ends, in causing rather than curing disease. But these are medical employments only vicariously; the skills necessary to them being derived from medicine only as a matter of convenience. And indeed, where doctors appear to be employed specifically as doctors with

things wrong other than illness (e.g. with obesity) or even with things that are not wrong at all (e.g. with pregnancy), such employments are in general covertly medical, arising, for example, out of a concern for morbid complications. Diagnosis and treatment, then, as specifically medical procedures, must be understood, in their central applications at least, as the diagnosis and treatment of illness.

3. In physical medicine, however, this qualification may seem somewhat trivial. For, it could be argued, from a practical point of view whether or not someone is physically ill, is generally self-evident; so much so, indeed, that it would normally be assumed in clinical practice that if there is anything wrong, what is wrong is that the patient is ill. Furthermore, to attend to the question "is the patient ill?", might actually distract attention from the question "in what way is the patient ill?" And, since the answer to this latter question is an important determinant of treatment, attention to the former question would tend to distract attention from the material diagnostic issue. Finally, it might be claimed, even in those occasional circumstances in physical medicine in which whether or not a patient is ill has any practical significance, the question is settled in

practice by precisely the same diagnostic exercise (viz., history, examination, and laboratory tests) that would be carried out otherwise. Given this point of view then, it may seem that anything wrong with a patient, at least in physical medicine, can, and generally should, be assumed to be wrong as illness. And in consequence presumably, where discussions of the nature of diagnosis occur in the literature, the necessary qualification on the sense of "wrong", that "something wrong" means "something wrong as illness", tends either to be ignored (e.g. Crookshank, 1959) or introduced simply as an assumption of practice (e.g. Roth, 1976).

4. In psychological medicine, this practical point of view would carry little *prima facie* plausibility. But even in physical medicine, it is insufficient in at least three important respects. Thus, in the first place, in clinical practice, the question "is the patient ill?" (even given that there is something wrong), although no doubt less prominent than the question "in what way is the patient ill?" is nonetheless an important and not uncommon practical question in its own right (possibly more obviously so in family or general practice, than in hospital medicine). Secondly, where the question "is the patient ill?" is raised, it may be in

practice approached by history - taking, examination and laboratory tests: but it cannot be resolved solely on the results of these procedures. For these results may identify one or more recognised diseases, but, clearly, they will not exclude as yet unrecognised diseases. And indeed, even where a disease is recognised, this recognition is not derived from the results of history taking, examination and special tests alone; for these results, as descriptive of the patient, may identify a condition but they will not, in themselves, amount to the identification of that condition as a disease (what more is involved here, is, of course, the subject generally of the present study). Essentially, then, the results of the practical procedures involved in diagnosis, describe a patient's condition; but, in themselves, they neither identify the patient's condition as a disease (and so the patient as ill), nor do they exclude illness constituted by as yet unrecognised conditions. And this conclusion, furthermore, is far from trivial in its implications for clinical practice. For, to come to our third reservation about the practical view of "diagnosis", while knowledge of the condition of a patient may determine what can be done clinically, it is the status of that condition as illness, that governs what ought to be done about it, the very rights of

the patient, and the responsibilities of the doctor, no less.

5. Even in physical medicine, then, what doctors do involves much more than determining simply what condition a patient displays, and what can be done to alter that condition. On either side of these determinations, lie the crucial issues of whether the patient is ill, and what the doctor ought to do. Nonetheless, it could perhaps properly be maintained that in physical medicine we get along well enough in clinical practice without these refinements. Possibly, it might be admitted, it would be salutary for doctors sometimes to acknowledge more openly, that excluding known diseases does not exclude illness (it is certainly a too common presumption of doctors that, as Rousseau remarked in *The Confessions*, because they "understood nothing about (his) complaint, therefore (he) was not ill"): but whether or not a patient is ill, can be established at least to a good approximation, by examining clinically for those conditions currently recognised as diseases: and, given that we know what can be done about a patient's condition, what ought to be done about it is not generally in doubt. It is only when we turn to psychological medicine that issues of this sort figure prominently in clinical

practice; and this, it could be said, tells us more about the nature of psychological medicine than about the nature of clinical practice.

6. This version of the practical view is largely unexceptionable, though perhaps not very informative. Indeed, it acknowledges the essential similarity of clinical practice in physical and in psychological medicine. However, as we saw in Section I, it operates in the literature either explicitly or implicitly, pejoratively with respect to psychological medicine. That is to say, from the fact that conceptual issues are more prominent in (though not exclusive to) clinical practice in psychological medicine (viz., both as to diagnosis, what counts as "illness"; and as to treatment, what does "illness" count for), it has been widely assumed that the conceptual structure of psychological medicine is inadequate compared with that of physical medicine. In Section I, we argued generally that there was no justification for this assumption, and that it had operated to obstruct impartial analysis of the conceptual structure of medicine; which exercise, indeed, had actually been prompted by the conceptual difficulties presented by psychological medicine in clinical practice. In Sections IV:3 and IV:4, we will examine certain of these difficulties, and

present positive, if somewhat preliminary indications of the effectiveness of analysis, impartially derived, in resolving them. Our analysis, however, although developed thus far from examples of physical illness, has already provided important insights into the conceptual structure of medicine. And since these insights demonstrate certain specific ways in which the pejorative assumptions of the literature have obstructed understanding, a brief examination of them, by way of three mainly negative points, may usefully anticipate the more positive proposals of succeeding sections.

7. The first of these points concerns the genesis of the difficulty presented by the notion of "illness", specifically of the notion of "mental illness", in psychological medicine. The most obvious explanation for this, might seem to be that the constituents of illness ordinarily classified as mental illness, are more difficult to handle in some way, in particular in the scientific way, than the constituents of illness ordinarily classified as physical illness. For example, it could be said, the identification and description of emotions (a common constituent of mental illnesses) must surely be less reliable (both between observers,

and over a period of time) than the identification and description of sensations such as pain. And even if emotions may be reliably identified, attempts to determine their causes, in terms at least of brain function, normal or otherwise, have thus far been frustrated by the extreme technical difficulties involved in the scientific investigation of the brain itself.

8. Such difficulties certainly are important. Psychological medicine is indeed a most demanding clinical discipline, the mere identification of a patient's symptoms, let alone the full procedures of diagnosis and treatment, requiring considerable skill; and the so-called brain sciences are, no doubt, still in their infancy. It would however be a mistake to exaggerate the extent to which difficulties of this sort provide a sufficient explanation for the particular difficulties of practice presented by psychological medicine. For psychological medicine and physical medicine are not so very different in these respects as is sometimes supposed. Thus, in the first place, as Wing in particular has shown, a wide range of mental phenomena, including the emotions (at least in so far as these are constitutive of mental illness), may in fact be described with a high degree of reliability (Wing et al., 1974).

The reliable description of these phenomena requires some training, but then so does the reliable description of any clinical phenomena. Indeed, where the description of physical symptoms, and even of clinical signs and laboratory test results, has been examined rigorously, the reliability of such descriptions has been found to be much less than we might expect (e.g. Belk and Sunderman, 1947; Butterworth and Rappert, 1960; Etter et al., 1960). Furthermore, while causal considerations figure prominently in modern classifications of physical illness, and are important determinants of treatment (II:4;9), "symptomatic" disease categories were a necessary precursor of these, and in some instances (e.g. migraine and epilepsy, as noted previously) continue to have crucial prognostic and therapeutic implications. Similarly in psychological medicine, diseases defined symptomatically already provide for informed treatment decisions; and they must surely anticipate developments in our knowledge of brain function.

9. Hence our first negative point. Though psychological medicine and physical medicine differ, both as to the difficulty with which the constituents of mental illness and physical illness respectively may be reliably identified, and as to the extent of our knowledge of the underlying bodily (i.e. including brain) causes of these two kinds of illness, these

difficulties in themselves do not seem sufficiently severe or extensive to account for the particular difficulties of practice presented by psychological medicine. And indeed, as we shall see in more detail subsequently (Sections IV:3 and IV:4), these practical difficulties in psychological medicine arise most particularly in circumstances in which the symptoms presented by a patient are not primarily in doubt, in which the condition constituted by these phenomena is not at issue, and in which what can be done about the patient's condition is well established. For it is in these circumstances that the question "is the patient ill?" may be raised most distinctly from the related question, "what condition does he display?"; and it is in these circumstances also, that the answer to this question may determine crucially, from among the things that could be done about the patient's condition, what ought to be done about it. Furthermore, to the extent that in these circumstances, neither kind of issue, diagnostic or treatment, is governed solely by the facts of the case, it is in these circumstances also that these issues are most concerned with the meaning of "illness" itself, and with the evaluative rather than with the factual part of its meaning. Hence, given the increasing prominence of these issues in practice, our attention in the literature generally has been

well directed towards analytical enquiry; but our attention, as in the present study, should perhaps have been directed more specifically to the properties of "illness" as a value term.

10. However, the recognition that these issues are conceptual in nature, and concerned more with the evaluative than with the factual part of the meaning of "illness" has itself played an important part in generating the prejudice in the literature against the notion of "mental illness". Most obviously so, of course, in respect of those who, like Szasz, deny the notion any logical coherence whatsoever. But, besides the objections to this position noted in Sections I and II:4, it must be clear that the pejorative assumption upon which Szasz's argument relies, if not his conclusion, is mistaken. For, even if physical illnesses were not constituted as much by mental as by physical phenomena (III:5); and even if as we have suggested in the present section, the difficulties presented by "mental illness" were not presented in principle equally (though in practice less commonly), by "physical illness"; still it would not follow that, because the issues raised by a notion are evaluative rather than factual in origin (let alone conceptual rather than practical), the notion itself is incoherent.

It may be that the notion of "mental illness" is logically incoherent; it may be possible to show that it is so; but not on this ground alone. And indeed, to come to our second negative point, given that "illness" generally is a value term, and that its properties as instantiated even by physical illness are fully consistent with the evaluative part of its meaning, and in important respects explained by it (III:4), Szasz's position must now be seen to be implausible.

11. Szasz, however, is not alone in his denial of "mental illness" on this ground. For the recognition that the problems presented by the notion in practice are evaluative in origin has prompted also the tendency to define "illness" stipulatively in terms of "dysfunction" (III:3), and so, by mistaken implication (II:4), in a form that is value free. This strategy, as we might expect, is adopted most explicitly by those who have contributed most to the development of reliable descriptive clinical techniques in psychological medicine, or otherwise to the establishment of the subject on a firm scientific footing (e.g. Wing, 1973 - see III:4;6). And so, since it is identified with those who are for rather than against "mental illness", it is less obviously a strategy of denial. But, as we have

seen, such stipulative definitions, at best define conditions not diseases (III:4;6). And while, as we have claimed (II:4, and III:4;6), a proper recognition of the evaluative nature of "illness" leaves the scientific part of medicine intact, if the evaluative part of the meaning of "illness" is excluded from the conceptual structure of medicine, then, given the considerations of the present section, the subject ceases to be medicine at all. Our third negative point therefore, is that, whatever the importance of science in medicine, clinical practice itself is not wholly a scientific pursuit. Doctors may at times confine their attention to factual issues; but in thus confining themselves, doctors are not acting as doctors, but as scientists. Simply to be aware of this distinction might help to resolve some of the confusions of clinical practice; but, just as "mental illness" will not be denied because the problems presented by the notion are evaluative in origin, so these problems will not be resolved by denying the evaluative nature of "illness". On the contrary, if these problems are to be resolved, it would seem that it will be by way of a proper understanding of the evaluative as well as of the factual parts of the conceptual structure of medicine as a whole.

SECTION IV:2 MENTAL ILLNESS SIMILAR TO PHYSICAL ILLNESS

1. The analysis of "illness" developed in Section III, relied crucially on the notion of "action"; the origin of "illness" itself being identified in the experience of action failure in the absence of preventing causes, which identification then provided for a comprehensive account of its properties in ordinary use (including its status as a value term), and of the properties of the closely related notion of "disease". The kind of action that we had in mind in Section III, was action as it involves our bodies - bodily movement and lack of movement, either in their own right (III:2A), or in relation to feelings and sensations such as pain (III:2B). The notion of "action" however, as we shall see in the present section, is not limited to the things that we do as doing involves our bodies, but includes also the things that we do as doing involves our minds.

2. This property of "action" clearly has important implications for our understanding of the conceptual structure of medicine if our proposed interpretation of the notion of "illness" is correct. For in Section III, we were concerned with "illness" mainly as exemplified by examples of physical illness. But if "illness" is actually derived from "action" in the way that we have suggested, it would seem that "action" itself, being, as it were, both bodily and mental, might be the vehicle by which the results of

Section III could be generalised to examples of mental illness. In the present section then, we will examine this notion of "mental action" and the analysis of "mental illness" that it makes possible, considering mainly the similarities and parallels between "mental illness" and "physical illness", and their equal logical status as species of "illness". In the next two sections, IV:3 and IV:4, we will consider the differences between "mental illness" and "physical illness"; indicating how our proposed analysis of "illness" explains why "mental illness" should be in general more problematic than "physical illness", and how this analysis might help actually to resolve certain of the difficulties presented by "mental illness" in clinical practice.

3. The notions of "mental" and "physical" are of perennial philosophical interest, and this interest may seem at times to bear directly on the "problem of mental illness". It would appear, for example, to be argued by some, that mental actions, the things that we do with our minds, should properly be analysed as bodily actions (e.g. Ryle, 1949): and this, along with philosophical "anti-dualism" generally, has found its way into the medical literature as an argument against the conceptual soundness of the notion of "mental illness". However, as we noted previously in respect of the philosophy of action (II:3), since it is within our ordinary conceptual scheme that the notion of "illness" is set, it is within this scheme also that it is to be understood. That is to say,

in analysing "illness", whatever new insights we may hope to achieve, we must both begin with and return to its properties, and the properties of other pertinent notions, in our ordinary conception of them. Given then, the relevance of "mental action" to the present analysis, a preliminary account of the properties of this notion in ordinary use, and of its relationship to "bodily action", will be apposite. We will return in Section V to the points of contact between the present study and the wider concerns of general philosophy.

4. "Action", as we noted in Section III:2 A, is a species of "doing". And so far at least as this wider notion is concerned, there is clear evidence from ordinary use, from what we say about what we do, that what we do involves equally what we do with our minds and with our bodies. Thus, the question, "what are you doing?" may be answered in terms of mental activity, in terms that is of "thinking", "remembering", "imagining", "calculating", "paying attention", and the like. It is indeed, just as likely to be answered in these terms as in terms of bodily activity. The two kinds of answer may be combined in various ways (e.g. "calculating" may involve both mental and bodily activity); but an answer in terms of mental activity alone would be not only sufficient but entirely unremarkable. Furthermore, an account of a mental activity that was restricted to a description of associated or consequential bodily activities alone, would be insufficient, and

often misleading. In this kind of context therefore, what we do with our minds is not only distinct from what we do with our bodies, but both kinds of activity, mental and bodily, are necessary components of our ordinary conception of what we do.

5. Mental activity and bodily activity then, are similar in that either may, and both at times must be included in an account of what we do. This similarity, however, extends also to "intentional doing", to "doing" as constitutive of "action" (III:2A) For, in describing what someone is doing, the implication, for mental as well as for bodily doing, may be either that the activity is intentional or that it is not (or that there is some uncertainty whether or not it is intentional). And in consequence, that whole family of notions associated with "intentionality" - "deliberation", "praise", "blame", "trying", "responsibility", "guilt" and so on - arise equally in respect of mental activity as of bodily activity. Similarly, mental activity, like bodily activity, may be encouraged, solicited, required, or ordered; "do try to remember!", "think!", "pay attention!" all make sense in a perfectly straightforward way. We are limited, of course, in what we can do to comply with such demands by our native capacity for doing things with our minds; but we are limited in the same way in respect of bodily action, by our capacity for doing things with our bodies. There is, possibly, a difference of degree between the two kinds of activity, in that mental

activity is in general more automatic than bodily activity - the mind just "runs on" most of the time - but even so, there is no difference of principle.

6. But with this notion of "control", it may be argued, do we not come to a difference between mental activity and bodily activity that is more than a difference merely of degree? For thus far, we have in effect considered only the positive case, doing things with our bodies and with our minds, intentionally and not intentionally, and here no doubt the difference in the extent of our control over these activities is one of degree only. But when we come to the negative case, either failing to do things, or intentionally not doing things, the difference between mental activity and bodily activity surely, is more substantial. After all, the argument might continue, the mind, as we have just observed, does indeed "run on" most of the time; and for most of the time, this "stream of consciousness" is more or less automatic. Indeed, the idea of "mental inaction", of doing nothing at all with our minds, appears to have no obvious parallel with "bodily inaction". Both mind and body may be immobilised, but can we keep our mind immobile as we can keep our body immobile? And if it is argued in reply that "keeping our body immobile", properly understood, means "avoiding particular bodily movements" while a whole variety of other bodily activities continue more or less automatically; and that it is this automatic bodily activity that is the proper analogue of the stream of consciousness; even so, a

a definite difficulty would remain. For is there not something distinctly odd in the idea of-intentionally avoiding particular mental activities? And is this oddity indeed, in certain instances at least, not conceptual rather than merely contingent? It may be difficult (though not, apparently, impossible) to keep one's mind still, but the idea of so doing is not self-contradictory. But not thinking a particular thought, for example, would seem to involve thinking the thought of not thinking that thought, and so thinking that thought after all; and similarly, not remembering a particular memory would seem to involve remembering not to remember it, and so remembering it after all. Hence, this line of argument might conclude, if the barrier to not doing things mentally, at least in this kind of case, is conceptual, does this not represent a difference between mental and physical activity that is more than a difference of degree? And does this kind of case therefore, not set a limit to the parallel between mental and physical?

7. On closer inspection, however, the difference between mental activity and bodily activity, even in respect of instances of this sort, turns out to be less than is required for this conclusion. For the notions of "not thinking a particular thought" and of "not remembering a particular memory", although perhaps not as familiar as their positive counterparts, are nonetheless to be found in our ordinary conception of what we do. The advice, for example, to "forget

all about it", is commonplace enough; as is the proscription of particular thoughts (e.g. in moral education). But neither would be so, if it simply did not make sense to suggest that particular memories or thoughts could be avoided. Indeed, what we do in practice not to think of something, or not to remember, is to distract ourselves, to turn our attention elsewhere. And this, after all, is in principle only what we do to avoid some particular bodily movement; not stepping off the pavement involves staying on the pavement. Not doing one thing with our bodies means doing something else with our bodies, and not doing one thing with our minds means doing something else with our minds. It is much harder, certainly, not to think or not to remember, than not to make some particular bodily movement; we are, that is to say, less able with our minds than with our bodies intentionally to do one thing rather than another. But this difference is, as for the positive case, a difference only of degree. Even then, in respect of intentionally not doing things, mental activity and bodily activity are closely parallel; it is only the difference between them in degree of control that makes them appear dissimilar. And, to return to the other half of the negative case, since a difference in degree of control is plainly irrelevant to activity that is conceived as automatic or non-intentional in the first place, failing to do things with our minds (e.g. "I just forgot", "I made a mistake in the calculation", "I didn't think") does not even appear to be much different from failing

to do things with our bodies; both kinds of failure indeed, being equally familiar.

8. There are therefore close similarities between mental activity and bodily activity in both the positive and the negative case, in respect both of doing and of not doing things. The parallel between them however, extends further still. For both kinds of activity, although normally things that we do, may also be things that are done or that happen to us. The parallel in this respect between mind and body, is perhaps more obvious in the negative than in the positive case, in the experience, for example, of mental activity being prevented, interfered with, or disrupted, by noise or other distractions. But the positive case is represented also; one's attention being held, for example, or a memory being evoked. And if these activities are reflexive (the equivalent of one's arm jerking as a reaction to an electric shock, III:2A;), there are others that are more closely parallel passive movement as such (e.g. one's arm being moved by someone else,) Hypnosis, for example, or strong suggestion of any kind, may actually control mental activity. Even the idea that the thoughts in one's own head are actually thoughts of someone else, is not self-contradictory, and is, indeed, a well-recognised feature of some forms of psychotic experience.

9. Mental activity and bodily activity then, are similar in all these respects, as things that we may do or not do, both intentionally and not intentionally, and as things that may be done or may happen to us. This is not to say that there are no differences at all between them, other than differences of degree. There is, for example, no analogue in "mental activity" of the body in "bodily activity"; the mind, ordinarily understood, being no more than the sum of mental activity. But the two kinds of activity are similar at least in the respects that we have described. And since it is these respects that are relevant to the notion of "illness", the similarities between "mental activity" and "bodily activity" would seem to be sufficient for "illness" to arise in respect of either. That is to say, since "illness" is distinguished in ordinary use as "something wrong" with someone, both from things that they do and from things that are done or happen to them (III:2A;6), "illness" could be so distinguished in respect either of "mental activity" or of "bodily activity". And similarly, if the distinctions by which the ordinary use of "illness" is defined, have their origin in the experience of action failure in the absence of preventing causes (III:2A;17), the action concerned could be "mental action" as well as "bodily action". Indeed, given that, as it were, all the conceptual ingredients are there, if "illness" arises in respect of one kind of activity, then surely it should arise also in respect of the other. And since "illness" does arise in respect of bodily activity (being defined in ordinary use in

in the way that we have described, whether or not its origin is as we have proposed), why not also in respect of mental activity. So straightforward then, is the parallel between "mental activity" and "bodily activity" in those respects that are relevant to "illness", the onus of proof must be seen to rest not, as in the literature generally (I;4), with the advocate of "mental illness", but with the sceptic. For the issue, if issue it is, would seem to be not, as Szasz (1960, 1961), would have us suppose, whether mental illness exists. but why it should not.

10. Two moves, however, would remain available to the sceptic. One would be to argue that, although "illness" could in principle arise in respect of mental activity, it never did so in practice; so that in consequence, although the notion itself was sound enough logically, in actual use it was inappropriate. But this move, being more by way of an assertion than an argument, in itself would do nothing to resolve the difficulties presented by "mental illness", and it would be therefore of little interest in analysis. Furthermore, in running counter to the plain facts of ordinary use, it would be somewhat implausible. Much more plausible, however, would be the sceptic's other remaining move, to acknowledge that "illness" may be derived from "mental activity", but to deny that "illness" so derived may properly be identified as "mental illness". This, indeed, would seem, superficially at least, to be in accord with ordinary use. For the kind of illness that is most straightforwardly

analysed in terms of "mental activity", is that which is constituted by disturbance of the so-called "cognitive functions", memory, intelligence, attention, and the like. And illness of this sort, although ordinarily classified as mental illness (e.g. in the International Classification of Disease, 1978), has close practical links with illnesses ordinarily classified as physical illness. Indeed, the generic term for such disorders is "organic psychosis"; the "organic" signifying the importance of underlying bodily pathology in the aetiology of these conditions (although they are defined and diagnosed by changes in the patient's mental state); and, correlatively, the responsibility for treatment resting as much with physicians as with psychiatrists.

11. The sceptic then, might accede willingly enough to an extension of our analysis of "illness" to these cognitive disorders. Such an extension indeed, would be hard to deny, for the parallels between cognitive disorders and the examples of physical illness considered in Section III, are self-evident enough. "Illness" constituted, for example, by a failure to calculate (in practice these disorders usually present with multiple symptoms), would be distinguished ordinarily as "something wrong" with someone, both from things that happen or are done to them, (viz the calculation being prevented e.g. by distraction), and from things that they themselves do (viz intentionally not performing the calculation); and the origin of these distinctions could be identified

in the experience of mental action failure in the absence of frustrating causes (which here, straightforwardly enough, means finding oneself unable to carry out one's intention to perform the calculation in circumstances (including the difficulty of the calculation itself) that are apparently entirely favourable). All then, very much as described previously for "physical illness". But self-evident or not, the sceptic may suppose that he is giving very little away in acknowledging the parallel, since "illness" of this sort is anyway not so very far removed from physical illness.

12. The sceptic indeed, might argue further that the self-evidence of the parallel between organic mental illness and physical illness, should actually reinforce our doubts about the notion of "mental illness" in its other applications. For, he could point out, it is not by organic mental illness that difficulties of a conceptual kind are raised in clinical practice; and equally, it is not the use of "illness" in respect of such conditions that is at issue in the literature (Szasz, indeed, actually refers to such conditions as examples of "real illness", 1961). Hence, the "problem of mental illness" should be understood as shorthand for the "problem of mental illness other than organic mental illness"; and the sceptical position could therefore be understood similarly as scepticism about the use of "mental illness" in respect of mental conditions other than organic mental conditions. And scepticism in this form, the sceptic might claim, is supported by the parallel between "organic mental illness"

and "physical illness", because, just as this parallel implies that the use of "illness" in respect of organic mental conditions is logically sound (consistently with the uncontentious status of these conditions as illness), so it implies by contrast that the use of "illness" in respect of other mental conditions is logically unsound. Hence, to conclude this line of sceptical argument, the contrast between organic mental illness and other forms of mental illness is so sharp that organic mental illness, although indeed derived from "mental activity", might perhaps more appropriately be regarded as "physical illness" than as "mental illness" after all.

13. In this form however, the sceptical argument might have a boomerang effect. For although "organic mental illness" is certainly the most obvious derivative of "mental action", it is not the only derivative; and to admit the derivation of "illness" in respect of organic mental conditions because this derivation is analagous to the derivation of "physical illness" from "bodily action", is to go some way towards admitting its derivation in respect of these other conditions. "Obsessional neurosis" for example, and "dissociative hysteria", may both be analysed readily enough along similar lines. However, the derivative of "bodily action" that is directly analogous to "organic mental illness", is not physical illness in general, but only those examples of physical illness that are constituted by movement or lack of movement. And if we broaden our attention to those (far more commonplace, III:2B; 1) examples of physical illness

that are constituted by sensation or lack of sensation, the analogy between "physical illness" and "mental illness" also becomes in principle much wider in scope. For sensations were found to be constitutive of "illness", not because they are things that we do, but because, essentially, they are things that we do something about. But sensations are not the only mental phenomena that "we do something about"; we do something about a wide range of other mental phenomena - anxiety, sadness, hunger, thirst, and so on. Just what we do, and whether what we do allows an extension of our analysis of "illness" to "mental illness" constituted by such phenomena, we shall examine in Section IV:3. And the results of this examination will indicate the extent to which the sceptical admission of cognitive disorders as "mental illness", involves the admission of other mental conditions similarly.

IV:3 MENTAL ILLNESS DIFFERENT FROM PHYSICAL ILLNESS -
IN DIAGNOSIS

1. Many of the important conceptual difficulties presented by the notion of "mental illness" may be characterised, as we saw in Section IV:1, as difficulties either of diagnosis or of treatment. Both kinds of difficulty, however, being difficulties in the actual practice of medicine, are in effect difficulties in, or related to, the use of "illness" in respect of certain sorts of mental phenomena as these are exhibited by particular patients. Thus, the "diagnostic" difficulty, which we represented in Section IV:1 as that of deciding whether or not a particular patient is ill, in so far as it is a conceptual difficulty, is essentially that of deciding whether or not the use of "illness" is appropriate to that patient. And the "treatment" difficulty similarly, amounts to that of deciding the implications of the use of "illness" for the treatment of a particular patient, where the use of "illness" is assumed, in the context of ordinary clinical practice, to be appropriate.

2. But if this is so, the analysis of "illness" proposed in Section III, turns out to be particularly apposite, both in subject and in method. In subject, obviously enough, because, just as the difficulties presented by "mental illness" may be understood as difficulties in the use of "illness", so it was the use of "illness" that was analysed in Section III.

And in method also, for the analysis was developed in terms of the distinctions implied by "illness" in ordinary use, and difficulties in the use of "illness" may well represent difficulties in drawing these same distinctions. A similar approach, therefore, could prove effective in interpreting the difficulties presented by "mental illness", the results of Section III providing in principle for a clear characterisation of the nature of these difficulties, if not for their actual solution.

3. The difficulties presented by "mental illness" in clinical practice are, however, protean, and our treatment of them in the present study, will be neither comprehensive nor fully exhaustive. Rather, we will examine, in this section and in Section IV:4, certain representative examples of both main kinds of difficulty, diagnostic and treatment, drawing severally on the results of previous sections, as these are most obviously relevant in each particular case. Nonetheless, from this exercise, preliminary and piecemeal though it may be, a clear cumulative picture will emerge of the origin of the conceptual difficulties presented by "mental illness", and hence of their significance with regard to the logical status of the notion of "mental illness" itself; and some impression will be gained thereby, of the potential of our analysis for further more detailed interpretation of these difficulties individually, as substantial difficulties in the day-to-day practice of clinical medicine.

IV:3A MENTAL ILLNESS AND EVALUATION

1. "Mental illness" constituted by cognition or lack of cognition was analysed in Section IV:2 by analogy with "physical illness" constituted by movement or lack of movement. A similar analysis was possible in respect of both kinds of illness, because "cognition" and "movement" are similar conceptually in those respects that are required for the distinctions implied by "illness" in ordinary use. We anticipated, however, (III:5;6) that the analogy between "physical illness" and "mental illness" might be considerably extended. For "physical illness" is constituted also, and more typically, by sensations such as pain which are ordinarily taken to be mental phenomena, and so, *prima facie*, relevantly similar to many of those other mental phenomena that may constitute "mental illness".

2. The sensation that is most commonly constitutive of "physical illness", is pain (III:2B). And the most obvious analogue of pain, as a constituent of "mental illness", is anxiety. Anxiety indeed, is a very common constituent of "mental illness", and, where it is the most prominent constituent, characterises that particular variety of mental illness called "anxiety neurosis." In this section then, we will examine the parallels between "pain" and "anxiety" as these are

relevant to the distinctions implied by the use of "illness", and consider the implications of these parallels for our understanding of the properties of this particular kind of mental illness in ordinary use. We will mention also, though briefly, that other common neurotic disorder, neurotic depression.

3. Anxiety and pain are perhaps most obviously similar in that both may be provoked; both, that is to say, in the terminology adopted in preceding sections, may be experienced as things that are done or happen to us. But they are similar also in that both are things that we may do something about. They differ, it is true, both in the kind of circumstances in which standardly they would be experienced as things that are done or happen to us; and in the sort of things that we might normally do about them. Pain is associated standardly with damage to our bodies, threatened, incipient, or actual. While anxiety is associated with less immediate threats; with the anticipation of bodily pain or damage, to oneself or others, and the loss of well-being that this entails; and, more commonly perhaps in modern circumstances, with other threatened losses, loss of status, possessions, wealth and the like. Similarly, what we do about pain is simply to withdraw, usually, though not necessarily, by reflex bodily movement; but what we do about

anxiety is considerably more complex, and may involve doing things with our minds as well as with our bodies; planning and preparation, change of attitudes, adjustment of expectations, and so on; which activities indeed, are commonly, though not exclusively, intentional rather than reflex. But through all these differences, the essential similarities remain.

4. As with cognition therefore, in Section IV:2, so now with anxiety; the necessary conceptual prerequisites are there for "illness" to be constituted by anxiety; and therefore the onus of proof must be with those who would deny, rather than with those who would affirm, that "illness" ever is so constituted. And indeed, in ordinary use at least, the notion of "illness" constituted by anxiety is familiar, and readily interpretable consistently with our earlier analysis of "illness" constituted by pain. For anxiety, like pain, is constitutive of "illness", where the fact that someone is anxious is distinguished as something wrong with them both from something that is done or happens to them (viz, the circumstances being anxiety provoking circumstances), and from things that they do or fail to do (viz., simply failing or deliberately not making the appropriate adjustments). And these distinctions also, as with pain, may have their origin in the experience of failure of intentional action

in the absence of frustrating causes; a failure, that is, to adjust to threatened loss, despite the circumstances being apparently favourable. Furthermore, the very differences between them, in the kind of threat and the kind of adjustments involved, go some way towards explaining why pain should be constitutive of illnesses ordinarily categorised as "physical illness", while anxiety is constitutive of illnesses ordinarily categorised as "mental illness", even though pain and anxiety themselves, in our ordinary conception of them, are both mental rather than physical phenomena.

5. There are then, close parallels between pain and anxiety, in virtue of which "illness" constituted by either may be similarly interpreted. Nonetheless, as we have noted, "mental illness" constituted by anxiety differs from "physical illness" constituted by pain, and indeed from "mental illness" constituted by cognition, in being both more problematic in clinical practice and, correspondingly, more contentious in the literature. Indeed, if the parallels between pain and anxiety are as close as we have suggested, this difference is so marked as to appear to cast doubt on the conceptual importance of these parallels, at least in so far as the sense of "illness" is concerned. For surely, it could be said, there must be some important conceptual difference between "mental illness" constituted by anxiety and "physical illness" constituted by pain, for the differences in their properties in

ordinary use to be so considerable. We must look more closely then at the difficulties presented by "mental illness" constituted by anxiety, and at their interpretation under the analysis of "illness" in the form proposed.

6. Of the two main kinds of conceptual difficulty presented by "mental illness", that most commonly associated with "mental illness" constituted by anxiety is that which we have called "diagnostic" (IV:1;6). This difficulty, as we have seen (IV:1;8), is not to be understood generally as a descriptive difficulty. This is clearly so in respect of anxiety. For anxiety is at least as readily described as pain; rather more readily indeed, as constitutive of "illness", since the necessary subjective description may be less complex (the anxiety, for example, does not have to be localised), and there are physiological correlates of subjective anxiety more prominent and more specific than those associated with pain. The difficulty in this kind of case arises rather where the patient is taken to be anxious; and what is at issue is whether or not the use of "illness" is appropriate in respect of that particular patient in virtue of his anxiety (IV:3;2). Can the difficulty then, be understood, as we have suggested (IV:3;2), in terms of the distinctions implied by "illness" itself in ordinary use?

7. The most prominent of these distinctions in relation to anxiety, is that between "something wrong" with the patient and things that are done or happen to him (the other distinction figures also, but less prominently). It is, for example, made explicit in the International Classification of Diseases (1978), in which the anxiety of "anxiety neurosis" is described as "not attributable to real danger...." And the "diagnostic" difficulty presented by "anxiety neurosis", may indeed straightforwardly be understood, in many instances, as a difficulty in drawing just this distinction; in deciding, in effect, whether the patient is ill or simply has something to be anxious about. Which difficulty in turn, is clearly a product of the wide variation from person to person in the circumstances in which anxiety is provoked.

8. Now, there is of course a degree of individual variation in the circumstances in which pain is provoked. But this is much less than in respect of anxiety. Hence, at least one source of the greater "diagnostic" difficulty presented by anxiety may be understood in terms of the distinction between "illness" and things that are done or happen to one. However, we may gain further insight into this difficulty from that part of our analysis in which we have emphasised the nature of "illness" as

a value term. Thus, we have argued that pain and anxiety are provoked typically and centrally by bodily damage and by threatened loss respectively. But there is, surely, much greater individual variation in what counts as threatened loss than in what counts as bodily damage, the latter indeed varying hardly at all. Hence there will be a much greater variation in the circumstances in which anxiety is perceived as being provoked, and therefore as something that is "done or happens to one". But, "loss" and "damage" are value terms. Therefore, the variation in what counts as loss and what counts as damage, is a variation in the criteria for the value judgements that are expressed by them.

9. This clearly has important implications for our understanding of the differences between "mental illness" (at least of this sort) and "physical illness". In the first place, as we saw in Section II:4, if the criteria for "loss" vary more widely than those for "damage", what counts as loss will be more at issue than what counts as damage; and the issue will be a more overtly evaluative issue. This difference, furthermore, will be enhanced by other similar factors. In particular, by the fact that anxiety itself is less consistently negatively evaluated than pain (there is nothing

unusual, for example, in claiming to enjoy anxiety provoking activities such as rock climbing; whereas enjoying pain is something that is at the least eccentric). In the second place, corresponding with its more overtly evaluative nature, the issue will appear, like evaluative issues generally (II:4; 2-4), to be in some way more "subjective" and less "precise". Hence, taking these two points together, "mental illness constituted by anxiety" will be a more evaluative, more subjective and less precise notion in ordinary use than "physical illness constituted by pain". Though, consistently with ordinary use itself, the two notions will be different in these respects in degree rather than in kind.

10. These considerations then, allow us to explain the differences between "mental illness" (constituted by anxiety) and "physical illness", consistently with the analysis of "illness" developed in Section III. Hence the sceptical claim, in so far at least as this claim is a logical claim, appears to be mistaken. Indeed, on the present interpretation, the properties of "mental illness constituted by anxiety" derive from the properties of "anxiety" in just the same way that the properties of "physical illness constituted by pain" derive from the properties of "pain". The differences

between these two kinds of illness, therefore, derive from the properties of the phenomena by which they are constituted, not from some difference between them in the notion of "illness" itself. Indeed, in so far as "illness" in both contexts faithfully reflects these properties, "mental illness" is no more prejudiced conceptually by its more evaluative, more subjective and less precise connotations, than is "physical illness" by the lack of these.

11. Our interpretation of "illness", then, has provided some insight into an important aspect of the difficulties surrounding "mental illness". And although we have considered only "anxiety", a similar interpretation could in principle be given for "sadness", by substituting "actual loss" for "threatened loss". Furthermore, we have thus far employed only certain parts of our interpretation of "illness", and other parts would offer other insights. The more positive side to the sceptical view, for example, that taking someone who has "problems" to be ill, may detract from what they themselves can and should do about their problems (Macklin, 1953), is readily analysed in terms of the distinction between "illness", as something wrong with someone, and things that they do. Though conversely, to the extent that Szasz's (e.g. 1960, 1961)

"problems of living" may be identified with those "losses" that are among the provoking causes of normal anxiety and sadness, his claim that "mental illness" is just "problems of living" would have to be understood as a contingent not a logical claim; and, indeed, to rely on the very distinction (between "mental illness" and things that are done or happen to people) the validity of which he would deny. Our analysis, then, in these and other respects, shows signs of being relevant to our understanding of "neurotic mental illness". There are, however, other quite different kinds of mental illness, and it is to one of these that we must now turn.

IV:3B MENTAL ILLNESS AND INTENTION

1. There are certain disorders that figure prominently in psychiatric practice, which, although not conventionally classified together, are nonetheless similar in that they are constituted by disturbance of one or more of those mental phenomena normally identified as appetites. Included among these disorders, therefore, are conditions such as anorexia and bulimia, in which the appetite for food is disturbed; disorders of sexual appetite, whether increased, decreased, or anomalously directed; and the addictions, both to alcohol, and to other (illicit) drugs - for our appetites include not only those that are directed towards specific gratifications, together with their particular pleasures, but an appetite for pleasure itself. These disorders then, in being similarly constituted, are similar conceptually, and may conveniently be considered together. Indeed, the conceptual problems presented by them in clinical practice, although different in certain respects, show important common characteristics. We will examine two of these in the present section, both as characteristics of the "diagnostic" difficulty outlined in Section IV:1.

2. The first of these common characteristics is simply that the diagnostic difficulty, so far as this group of disorders is concerned, is a common and considerable difficulty. That is to say, in clinical practice, there is commonly some uncertainty whether

particular patient should be regarded as constitutive of illness, and the question therefore is much at issue. More so perhaps than in respect of many other mental phenomena. Certainly, discussion of this question in the literature, is much more widespread in respect of appetite than in respect of many other mental phenomena, including anxiety. Furthermore, such discussion, as we shall see in more detail subsequently in this section, is mainly among those who are practitioners; and practitioners who are for, rather than against, the notion of "mental illness" generally. Indeed, the sceptics of "mental illness", although ready enough to condemn the use of "illness" in respect of mental phenomena that are less contentious clinically, are, by and large, oddly silent on its use in respect of appetite.

3. The second characteristic that is common to the diagnostic difficulties presented by these disorders, is the extent to which their diagnosis involves distinguishing them not only from health, an essentially non-moral notion, but from a variety of moral notions also. We characterised the diagnostic difficulty generally in Section IV:1, in terms of the question "what counts as illness?"; and what is implied by this question normally is that what is not illness (or some derivative such as disease) is, by and large, health. But in respect of "disorders of appetite", what is not illness may be, in addition to health, a crime, a sin, or a virtue. Anorexia and

bulimia, for example, are illnesses, but gluttony is a sin and abstinence a virtue. Indeed, certain of these conditions vary dramatically in their status from culture to culture and over relatively short periods of time. Homosexuality, for example, has been variously regarded in the space of only twenty years, not only as a sin and as a crime, but as a disease, and as a normal variant of human sexuality. This kind of distinction is not confined to disorders of appetite; phobias for example might be distinguished from cowardice, and retarded depression from sloth. Indeed, the ascription of "illness" generally, as we noted in III:2A;12, and will examine in more detail in Section IV, may in certain circumstances constitute an excuse moral or legal. But it is disorders of appetite that, most commonly and with most difficulty, must be distinguished in this way. Hence one object of analysis must be to explain this property of these disorders (though not, in itself, to provide a determination of what their status should be, I;15); and hence to interpret its reflection in the diagnostic difficulties of clinical practice.

4. There are then these two characteristics of the diagnostic problems presented by disorders of appetite; their prominence, and their close relationship to morals. Among these disorders, alcoholism is perhaps the most familiar; certainly, it displays both characteristics

in good measure. In the remainder of this section, therefore, we will examine "alcoholism" in more detail by way of interpretation. Though our conclusions will apply in principle to disorders of appetite generally.

5. The notion of "alcoholism" as a "disease" has, apparently, fairly recent historical origins (Jellinek, 1960), and it remains highly contentious (Kendell, 1979). But the arguments both for and against the notion, as we noted previously, have been advanced largely by doctors themselves. These arguments, indeed, are closely similar to those that have been adopted elsewhere in the literature, for and against the concept of "mental illness" generally. Edwards and Gross (1976), for example, emphasise the importance of the notion in clinical work and in research, and suggest certain ostensibly factual criteria by which the "syndrome" may be defined, as a preliminary to scientific research into its "psychological basis". Robinson (1972), on the other hand, argues against the notion on the grounds that the "disease label" in this context is socially arbitrary. Indeed, Kendell (1979), whose arguments for the concept of "mental illness" were examined in Section I in contrast to those of Szasz, has presented a case against the disease concept of alcoholism which could well derive from Szasz himself. Thus, he describes the concept as the result of a "campaign", with a definite historical origin (viz., with Thomas Trotter in 1804) which has now become "official dogma" (p.367); this concept, he says, has some humanitarian

benefits, but it has now outlived whatever usefulness it may have had (p.367); it is "convenient" to all concerned (viz., industry, politicians, and patients themselves), but the disease concept prevents us from tackling the problem effectively.

6. In this form, objections to the disease concept of alcoholism, like objections to other kinds of mental illness (IV:3A), would seem to draw on the distinctions implied by "illness" itself. And they would be susceptible therefore, to the analysis of "illness" developed in terms of these distinctions in Section III:2A. More commonly, however, it is assumed in the literature that "alcoholism" is a disease, and that the problem is straightforwardly one of definition. The varieties of this approach to the problem are largely descriptive, as, of course, are those that have been adopted in the literature in relation to the definition of "illness" (II:4, III:4). The definitions proposed then, may most conveniently be examined in relation to what we called in Section III:2B, the "alternative" line of argument; that from the inadequacy of descriptive definitions, to the nature of "illness" as a value term.

7. The temptation to define "illness constituted by an appetite for alcohol" descriptively, is perhaps stronger than the corresponding temptation in respect of other mental phenomena, because it is so closely and so specifically associated with a particular behaviour. Various kinds of statistical definition

might thus seem appropriate - e.g. that the alcoholic drinks more than others, by an amount that could be specified. Moreover, while statistical definitions of "disease" generally may fail to distinguish, for any given characteristic, abnormally good from abnormally bad extremes, for alcohol consumption the "bad" end of the distribution would seem to be self-evident. However, besides objections of a general kind to definitions of "disease" in this form (II:2, III:2A), it would seem that those identified as "alcoholics" may actually drink less than many normal subjects (Williams and Strauss, 1950). And in any event, it is far from self-evident that the less one drinks the better, even if "better" means better for one's health. Certainly there would be no obvious contradiction in taking someone to be an alcoholic, the volume of whose alcohol consumption as such was normal. Similar considerations would apply to definitions of "alcoholism" that relied on qualitative rather than quantitative differences from normal. Edwards and Gross (1976), for example, emphasise the "narrowing in the repertoire of drinking behaviour" exhibited by alcoholics; but the diagnosis surely could not credibly rest on the "symptom" of "having a favourite drink". Both kinds of observation, of course, may both raise the possibility of alcoholism (II:2;8), or describe varieties of alcoholic (III:4). The drinking of alcoholics, that is to say, tends to be both excessive and stereotyped. Both kinds of observation therefore, are important clinically and in research,

but neither provide a sufficient definition of "alcoholism" itself.

8. The next most obvious step then, if descriptions of alcohol consumption as such will not do, is to extend the scope of the definition to include descriptions of its causes and/or consequences. And such definitions indeed are superficially plausible. For it might be supposed that although "disease" generally may not be defined in this way (because such definitions are either vacuous or tautological, II:2;3), a particular disease, and hence the particular disease "alcoholism", nonetheless may be: "alcoholism" so defined, being "an appetite for alcohol that is caused by and/or results in disease". Both types of definition, causal and consequential, occur, though the latter are more common. The Shorter Oxford English Dictionary, for example, has it as "...diseased condition produced by (alcohol)"; and Dorland's Illustrated Medical Dictionary, as "...the morbid effects ofalcoholic drinks". Similarly, the World Health Organisation, in an early attempt at definition (International Classification of Diseases, 1957), included "interference with mental and bodily health" as one of the consequences of alcohol consumption that marked the consumption itself as a disease. Possibly the nearest approach to a causal definition is that of the American Medical Association Standard Nomenclature of Diseases (Plunkett and Hayden, 1952), in which

"alcoholism" is included as a disease of the "psychologic unit", the implication being that it is a condition with a "psychogenic origin". But all such definitions, even as definitions of particular diseases, are clearly insufficient: for while illness may be differentiated into diseases by its causes, and also, in principle at least, by its consequences (III:4;9), the causes and consequences of illness are only the causes and consequences of illness, not, or not necessarily, "illness" as such. After all, drinking alcohol is a necessary cause of "alcoholism", but, ex hypothesi , not in itself a disease.

9. This distinction has in fact been made fully explicit in much of the literature in recent years. The World Health Organisation, for example, now distinguishes "alcoholism", which is called the "alcohol dependence syndrome", from a variety of alcohol related problems such as the alcoholic psychoses (categories 303 and 291 respectively in the International Classification of Diseases, 1978). "Alcoholism" itself in this classification is partly described and partly defined, but in such a way as to make a compulsion to drink central to the notion; it is said ... "always (to) include a compulsion to take alcohol". And with this element of "compulsion", we would seem to come close to what we have in mind in taking someone to be an alcoholic. Certainly it recurs throughout the literature, albeit expressed in different ways. Keller (1960), for example,

makes "loss of control over drinking the pathognomonic symptom", noting his agreement in this with Jellinek (1952); and "loss of control", he says, means that an alcoholic cannot stop drinking "at will". Similarly, Slater and Roth, in the third edition of their textbook (Meyer-Gross, Slater and Roth, 1969, p.397) regard alcoholism as a disease, alcoholics being ... "those compulsive drinkers losing control over the amount they drink."

10. Definitions along these lines, besides corresponding with our intuitive sense of the notion of "alcoholism", offer two definite advantages. In the first place, there would seem to be a link of some conceptual importance between "loss of control" and the notion of "illness" generally. To say, for example, that someone has no control over what they do, is to say that in some important sense what they do is not their own action (Glover, 1970). Prima facie then, "loss of control" would seem to bear some conceptual relation to that distinction which, in part, defines "illness" itself; between "something wrong" and things that we do (III:2A; 4). And indeed, that "loss of control" is involved in the concept of "disease" has been noted in the literature; in respect of obsessive - compulsive disorders for example (Edwards and Gross, 1976), and as central to "disease" generally (Flew, 1973). But, in the second place, if "loss of control" has this central importance, this would seem a particularly

happy outcome for those who attach some importance to the definition of "disease" being value free. For whether or not something is under control, it may be said, is surely a matter of fact; and the notion of "loss of control" therefore, would seem to provide for a definition of "alcoholism" by description alone. Indeed, a subjective report of "compulsion" is included by Edwards and Gross (1976) among the features of their syndrome of "alcohol dependence"; and some attempt to provide a standardised description of this experience for use in research is reported by Cartwright et al., (1978).

11. So far so good then. In fact, rather too good perhaps; for the very straightforwardness of definitions of "alcoholism" along these lines, would seem to conflict with the extent of the "diagnostic" difficulty presented by the notion in clinical practice. That is to say, if "alcoholism" may be defined in terms of "loss of control", and if such definitions offer all these advantages; being intuitively credible, consistent with the sense of "illness" generally, and yet a descriptive account of the term; why, we must ask, should "alcoholism" be so contentious?

12. The answer to this question suggested by the "alternative" form of argument of Section II:4, together with the considerations generally of Section III, is that, appearances notwithstanding, definitions of "alcoholism" in terms of "loss of control" must be defective in

that they omit or suppress the evaluative element in the meaning of "illness" generally. It was, after all, this element that was crucial to our explanation of the "diagnostic" difficulties presented by "neurosis" (IV:3A). In this instance, however, the suggestion, as it stands, is less plausible. For the "diagnostic" difficulty presented by "anxiety neurosis" was shown to reflect the large variation in our values as these are involved in different ways in the meaning of the term itself. But our values generally in relation to alcohol and its effects, and what we do about them, would seem to be well circumscribed. It is true, of course, that the central notion, of "loss of control", although perhaps generally negatively evaluated, is not necessarily so; and indeed in certain circumstances may be most positively evaluated - e.g. when power-centred steering overrides a car driver's control when one of his tyres bursts at speed; or when the respiratory centre overrides a child's deliberate attempt to hold its breath. And it is true also that definitions of "alcoholism" in terms of "loss of control", necessarily imply a negative evaluation, which is not made explicit. But, there is, surely, little scope for credible variation in the criteria for good and bad "loss of control"; certainly so far as control over alcohol consumption is concerned. So that, the fact that the negative evaluation implied by "alcoholism" (as a disease) is not made explicit, should be of little importance in practice. Indeed

we should perhaps expect, from the results of the preceding section, that the "diagnostic" difficulties presented by "alcoholism" should be much less, rather than more, significant than those presented by conditions such as "anxiety neurosis".

13. However, the "alternative" form of argument did not end with the demonstration that "dysfunction" is a value term, but went on to examine the kind of value that is expressed by it. In Section II:2, we noted that "dysfunction" does not imply moral or aesthetic value; and in Section II:4, we identified the relevant kind of value with that which is implied by "purpose"; the evaluative element in the meaning of "dysfunction" being derived, by way of "function" itself, from people's purposes for things. At the end of Section III:2A, we observed that a similar argument might identify the particular kind of value that is expressed by "illness"; for this also is not moral or aesthetic value (III:2A) And "illness", like "dysfunction", appears to bear some important logical relation to people's purposes (III:2A). In the case of "illness", however, this relation appeared to be mediated by "action", which suggested the possible logical importance of the notion of "intention".

14. With "intention", however, we have a notion which, on the face of it, might well cause difficulty in relation to "appetite", and so in relation to illnesses constituted by disturbance of appetite, such as "alcoholism". For, as we shall examine in more detail subsequently, "appetite" bears a more intimate conceptual relationship to "intention" than does "bodily movement" (III:2A), "pain" (III:2B), "cognition" (IV:2), "anxiety" (IV:3A), or any other constituent of "illness" that we have considered thus far. Consistently with our established policy (Section I;14) we shall not here examine the philosophical difficulties presented by this relationship in their own right; but rather sketch the relationship itself, as ordinarily understood, indicating the ways in which it might explain the "diagnostic" difficulties presented by "alcoholism" and related disorders, in everyday clinical practice.

15. The argument then, might be developed thus. "Illness", as we have seen, is distinguished from things that people do. But the things that people do qua people, they do intentionally, viz., as constitutive of actions (III:2A;12). Hence, in taking someone to be ill, we draw implicitly on whatever process is involved in attributing intentions to people. This process, no doubt, is intricate

enough, but it involves at least two classes of information; information about the person to whom the intention is attributed, and information about people's intentions generally. Information of the first kind includes what the person concerned says about his intentions; and, perhaps of equal weight, information about what he does, both on the occasion in question and generally in similar circumstances. Information of the second kind is drawn largely from that body of more or less intuitive knowledge of the things that people do intentionally, knowledge that we acquire in the ordinary experiences of our lives, both subjective and of other people. It may be difficult sometimes to attribute intentions with any confidence - the evidence may be insufficient, for example, or contradictory. But we do attribute intentions, and we assume that in general we do so accurately; this assumption is crucial, for example, in jurisprudence.

16. In respect of appetites, however, and what we do about them, the ordinary process by which we attribute intentions may present difficulties of a particularly acute kind. For "appetite" itself, as we have noted, is closely related to "intention" in our ordinary conceptual scheme. And this relation indeed, may seem to be a logical

relation, to the extent that "intention" and "appetite", in our ordinary conception of them, both have something to do with what we "want". The assertions, for example, "Y is X's intention" and "X has an appetite for Y" both entail "X wants Y". There are, however, as Hare (1968) has emphasised, different kinds of "want"; and the "wants" implied by "intention" and by "appetite" respectively in ordinary use are clearly not identical - the assertion that "X does not intend to satisfy his appetite for Y", for example, not being self-contradictory. In this kind of case, X is taken to want (= has an appetite for) Y, but also to not want (= intend to gratify his appetite for) Y.

17. This kind of case, however, brings out an important feature of the way in which "intention" and "appetite" are related in our ordinary conception of them. Thus, if X is taken to have an appetite for Y which he does not intend to satisfy, we should be inclined to say that X must want something else more than Y, the gratification of which latter "want" is incompatible with the gratification of his appetite for Y. And the "must" involved here, is surely a logical "must"; for it would not make sense at all to assert that "X does not intend to satisfy his appetite for Y", unless some countervailing intention was known or assumed to be present (even if this countervailing intention is simply to prove one's self control, or indeed to prove a point in argument).

"Intention" then, in our ordinary conception of the notion, implies not so much "want", as "really wants". And the logical relation between "intention" and "appetite" derives from the fact that what we want (as appetite) contributes to what we really want (i.e. intend), though our wants (as appetites, or otherwise) may conflict. And, consistently with this ordinary relation of intention and appetite, what someone does by way of gratifying an appetite that is taken to be a strong appetite, would normally be taken to be done intentionally.

18. Normally, but not, of course, necessarily. Indeed, it is precisely this intention, to gratify a strong appetite, the attribution of which is denied in respect of the alcoholic. That is to say, the alcoholic is taken to have a strong appetite for alcohol, the gratification of which is nonetheless not taken to be intentional. And the reasons for denying that the alcoholic's drinking is intentional, are evident enough; for his "subjective sense of compulsion" (see para 10 above), together with the fact that he drinks a great deal, suggest that he very much wants (has a strong appetite for) alcohol; but he tells us also that his drinking is not intentional (it is "out of control"), and this is strongly supported by the consequences of his drinking, which are such that people generally would not intentionally entertain. Indeed, the prominence of clinical definitions of "alcoholism" in terms

of its consequences (medical, social and psychological), derives from their significance as consequences that people, by and large, could not credibly be taken to intend (a point that Keller, 1960, seems to draw on in making the key criterion of whether an "ill effect" is relevant to the diagnosis of "alcoholism", whether the individual would be "expected to reduce his drinking (or give it up) in order to avoid (it)...") The notion of "alcoholism", after all, would not have arisen at all, if the consequences of drinking alcohol (in whatever amount) were entirely harmless.

19. The notion of "alcoholism" then is readily enough derived consistently with the process by which intentions generally are attributed. And hence, as we have seen, it is not a notion that is in itself obscure (para 11 above). In application, however, to particular cases, the difficulties presented by it (the "diagnostic" difficulties) are considerable. And we may now see why this should be so. For, precisely because our appetites are among our "wants", such evidence as may be taken to indicate that the alcoholic's drinking is not intentional, may be taken equally to indicate that it is intentional. For it would always be open to us to take the fact that the alcoholic drinks despite knowing the consequences, as an indication that he really wants to drink, and does so intentionally. And because the choice between these two options is essentially one of weighing one "want" against

another, while the evidence is relevant in principle equally to both, there is no determinate way in which the choice may be resolved. Either the appetite for drink is irresistible, or it is not resisted; either is intelligible, and there is no way in which we can decide finally between them.

20. The prominence of "diagnostic" difficulties in relation to "alcoholism" is thus a product of the difficulty of attributing intentions in relation to appetites, which in turn is a product of the process by which intentions are attributed generally in our ordinary conceptual scheme. Just as, therefore, "anxiety neurosis" reflects the properties of "anxiety", so "alcoholism", in this respect, reflects the properties of "appetite". That this is so, however, is shown even more clearly by the second characteristic of "disorders of appetite", their particular link with morals (para 3 above). Thus, "alcoholism" as a species of illness, is distinguished from the vice, and sometimes also the crime, of "drunkenness", because "illness" itself is an excuse (moral and/or legal). This property of "illness" in our ordinary conceptual scheme, will be examined in the next section. Essentially however, it is explained on the present interpretation of "illness", by the origin of the notion itself in the experience of "action failure". For that which is not done intentionally, viz., as constitutive of "action", cannot in general be judged morally (III:2A).

But the particular prominence of moral categories in relation to disorders of appetite, derives simply from the prominence of appetites, and what we do about them, in moralities themselves. Which prominence, no doubt, may in turn derive from the close conceptual relation that exists between "appetite" and "intention" generally in our ordinary conceptual scheme.

IV:4 MENTAL ILLNESS DIFFERENT FROM PHYSICAL ILLNESS
IN TREATMENT

1. Conceptual difficulties, as substantial difficulties in clinical practice, are, as we have seen (IV:1), a good deal more prominent in psychological than in physical medicine. In the last section, we examined certain examples of these difficulties as they arise in connection with the clinical procedure of diagnosis. There are however a large number of psychological conditions that do not present "diagnostic" difficulties in clinical practice, at least to the same extent. Notable among these, are a majority of those conditions that are conventionally grouped together (e.g. in the International Classification of Diseases, 1978) as "psychoses". The psychoses are broadly subdivided into "organic" and "functional" or "non-organic" psychoses. The former are characterised primarily by disturbance of cognitive function, which kind of disturbance we considered in Section IV:2. In the present section, we shall be concerned mainly with the "functional psychoses". In this section therefore, the term "psychoses" will refer to the functional psychoses, unless otherwise specified.

2. The psychoses provide paradigm examples of "mental illness", for not only are they, by and large, reliably identifiable in clinical practice (Wing et al., 1974),

but they are very widely identified as "disease". In Campbell et al's (1979) study, for example, in which subjects were asked to identify from a list of conditions, those they considered to be diseases, schizophrenia was considered to be a disease by 78% of medical academics, and by 92% of general practitioners; thus ranking slightly behind diabetes mellitus (92% and 100% respectively), but close to duodenal ulcer (82% and 94% and coronary thrombosis (80% and 87%), and well ahead of many other conditions, both physical (e.g. hayfever, 72% and 63%) and mental (e.g. depression, 50% and 68%; alcoholism, 60% and 85%). Nor is this status peculiar to any one culture, being widely represented in societies of many different kinds (Wing, 1978).

3. The status of these conditions as "disease", furthermore, in so far at least as the psychoses correspond with the more familiar "lunacy" or "madness", cannot credibly be regarded as a modern invention. The sceptics of "mental illness" commonly imply some illegitimacy in the origin of the notion, by suggesting that it is a recent derivative of the long established notion of "physical disease". Szasz, 1976, for example, claims that Kraepelin and Bleuler "did not discover the diseases for which they are famous; they invented them." But madness is clearly represented

as a disease in Plato's Republic (Kenny, 1969); and indeed, causal theories of madness in terms of brain disease, were advanced by Hippocrates, Galen, and other classical physicians, similar views surfacing repeatedly in subsequent centuries (for review, see Zilborg and Henry, 1941). Whether one regards classical philosophers and physicians as "inventing" the concept of "mental illness", or simply as recognising madness for what it is, will no doubt depend on one's preconceptions about mental illness generally. (Though, if historical precedence were a sufficient guide to the validity of a notion, the use of "disease" even in respect of physical conditions, would be suspect; since, as Kenny (1969) has observed, the earliest recorded use of the Greek word for "healthy" occurs in the Iliad, in respect of a sound argument.) But either way, such geneological suspicions as the sceptic of "mental illness" may raise, must be raised against the psychoses in a conceptual tradition of at least two thousand years.

4. It would seem then, that if the case for the validity of the notion of "mental illness" were to rest on any one condition or kind of condition, the psychoses would offer the most advantage. But despite this the psychoses figure more, rather than less, prominently in the sceptical attack on the concept

of "mental illness". And the reason for this, in so far at least as this attack has its origins in the conceptual difficulties presented by "mental illness" in clinical practice, is evident enough. For the psychoses, although conceptually uncontentious in the diagnostic part of clinical practice, are far from problem-free in treatment. That is to say, in the terminology of Section IV:1, the conceptual difficulties that are characteristic of the psychoses in clinical practice, are "therapeutic" rather than "diagnostic" difficulties. In respect of these conditions then, it is the implications of taking someone to be ill, rather than whether they are ill, that is most at issue clinically.

5. Of these "therapeutic" difficulties, possibly the most prominent is one that may straightforwardly be understood as a difficulty in medical ethics (IV:1;4), viz., the ethics of compulsory treatment. This difficulty is not confined to the psychoses, but, as we shall see, it is one that arises in the management of certain kinds of psychotic illness in a peculiarly acute form. It is this form of the difficulty that we will examine in the present section, indicating its origins in the concept of "illness", and hence the relevance of our present analysis to the contingencies of clinical practice in this case.

6. The particular ethical difficulty presented by the compulsory treatment of psychotic patients, may be provisionally characterised thus. Doctors, by and large, are constrained by the Hippocratic principle, that they have an obligation to act generally in the interests of their patients. The best guide to a patient's interest is normally what he wants (exceptions to this are noted in paragraph 11 below). Hence, where a doctor's perception of his patient's interests differs from what his patient wants, it is in general the latter that governs the interpretation of the doctor's Hippocratic obligation in treatment. The Hippocratic obligation is not absolute of course. In certain circumstances, a doctor's non-medical obligations (e.g. to his family) may take precedence; as indeed, may his specifically medical obligations, for example, where his patient's illness, whether mental or physical, constitutes a substantial danger to third parties. But in the management of psychotic illness, circumstances arise (e.g. with suicidal psychotic depressives), in which the doctor's Hippocratic obligation, to act in the interests of the patient himself, seems to be served by treating the patient even though treatment is known to be not what the patient wants. There arises therefore, a conflict or tension between the normal interpretation of the Hippocratic obligation, and the interpretation

imposed in certain circumstances in the management of psychotic patients. In these circumstances, the doctor may be obliged to act coercively; in general such action is ethically unsound; but coercive action is necessary to satisfy the doctor's specifically medical obligations to his patient.

7. Notwithstanding this ethical tension, however, the Hippocratic obligation to compulsory treatment is very widely recognised. Indeed, it is acknowledged by doctors themselves almost unanimously and with unusual passion. Wing (1978), for example, the doyen of scientific detachment in psychiatry, uses the term "repellant" to describe the attitude of those who would refuse to treat suicidal patients compulsorily. Compulsory treatment does have its opponents, of course, but, as they are often the first to observe, they are in a small minority. As the 1970 platform statement of the American Association for the Abolition of Involuntary Mental Hospitalisation claims, "No group of physicians, lawyers or social scientists have ever rejected such interventions (i.e. compulsory treatments) as contrary to elementary principles of dignity and liberty and hence as morally and professionally illegitimate." (Brooks, 1974). Indeed, so general is the recognition of the need for compulsory treatment, that the medical obligation entailed by it is commonly given the authority of law. In the United Kingdom, the mental

Health Act, 1959, provides for compulsory treatment where "a patient through disease of the mind is a danger to himself ..."; similar legislation existing in other parts of the world (McGarry and Chodoff, 1981). And although the Act refers broadly to "disease of the mind", its provisions are invoked almost exclusively in respect of psychotic illness.

8. Nonetheless, despite such widespread, clear and open acknowledgement, the necessity for compulsory treatment of psychotic patients is generally regarded as an unfortunate necessity. There are various reasons for this. In the first place, it is, as we have said, in flat contradiction to the normal form of the Hippocratic obligation. There is, therefore, a proper uneasiness over the use of compulsion in clinical practice. This uneasiness, furthermore, is fuelled by the fact that compulsory treatment is so self-evidently open to abuse. And indeed, by the fact that such abuse is no mere theoretical possibility, but occurs in practice. In the United Kingdom, and other democratic countries, we can afford a fair degree of confidence that compulsory treatment is used by and large in the interests of the patient; and the Mental Health Act, 1959, incorporates a series of safeguards against the occasional temptation to misuse its provisions

for personal ends. But in the Soviet Union, compulsory treatment is employed, under legislation that is closely similar to our own, apparently for political purposes (Bloch and Reddaway, 1977). And the recognition of this practice as an abuse of compulsory treatment (and doctors themselves have been most forward in condemning it), actually entails the recognition that compulsory treatment is abused in practice. Some Soviet doctors, it is true, do not regard this use of compulsion as improper. But this view, if taken seriously merely adds to our uneasiness about compulsory treatment; for it implies that compulsory treatment may be abused inadvertently - in execution, if it is false; in default, if it is true.

9. The obligation to compulsory treatment then, is one that is held firmly, but with a sense of unease. For the proper object of the obligation would seem to be not so self-evident as the obligation itself. But this observation, and the political use of compulsion in the Soviet Union, may appear to give some credence to the views of those who regard all compulsory treatment as ethically unsound. For the opponents of compulsory treatment commonly take the view that it is used always, and not just in the Soviet Union, for political ends. Foucault (1967), for example, considers compulsory treatment to be but one of the weapons employed by psychiatrists

as the agents of whatever political power is extant, to persuade their (sane) patients unwillingly to adapt to the standards of an (insane) society. And Szasz (e.g. 1973, 1976) has argued a similar case.

10. From the point of view of established medical practice, such criticism may seem ineffective. Wing (1978) for example, gives Foucault short shrift. Certainly, it may be said, some clarification of the proper use of compulsory treatment is required. But the obligation to treat psychotic patients compulsorily has such widespread intuitive appeal, that its rejection wholesale is nothing short of absurd. But such ethical intuitions, although necessary in the day-to-day conduct of our lives, a fortiori, are not self-justifying. They constitute, in Hare's (1976) phrase, only "level-1 moral principles", which, when they fail or are otherwise in doubt, must be subjected to some form of critical appraisal. Such appraisal may involve analytical enquiries into the meanings of moral and other relevant words, one object of which is to provide the logical equipment for moral thinking (Hare, 1963). But ordinarily it involves only the attempted subordination of the intuition in question to some more general moral principle, the validity of which is assumed.

11. It is this latter kind of moral reasoning that we find most widely deployed in the justification of compulsory treatment. The relevant moral principle, obviously enough, being taken to be that a doctor's Hippocratic obligations in treatment (para 6 above) are not governed by what his patient wants, if what his patient wants is not the best guide to his patient's interest. Circumstances in which this is so, are, as we have said, somewhat unusual, but they are by no means rare. Thus, Wing (1978), Glover (1970), and others, illustrate the principle with children, mental defectives and demented; and Schapiro (in De Reuck and Porter, 1968), with unconscious patients. The former because they lack or have lost the information and/or experience necessary for what they want to correspond with their interests; the latter because, in the absence of prior indications, what they want must be assumed. And compulsory treatment of such patients is indeed ethically uncontentious, and properly illustrates the moral principle concerned. But the difficulty with this kind of justification, is that it is far from clear just why psychotic patients should be subordinated to this principle. They neither lack nor have lost information ("functional psychoses" are differentiated clinically from "organic" psychoses partly on this point); and what they want, is generally evident enough. It is of course assumed that there is

some sense in which their interests are not represented by what they want; and it is for this reason that compulsory treatment is taken to be justified. But the sense in question, as Flew, 1973, indicates, is not the same as in respect of those uncontentious cases so commonly quoted in the literature. It would seem, then, that it is the sense of "psychosis" itself that is at issue; for it is only if psychotic patients are similar in the morally "relevant respect" (Hare, 1963) to these uncontentious cases, that compulsory treatment of psychotics is justified by the moral principle under which such cases fall.

12. We are drawn, then, if we attempt to justify the compulsory treatment of psychotic patients, into analytical enquiry. Psychotics are recognised as an exception to the normal form of the Hippocratic obligation; it is the sense of "psychosis" that is crucial to this recognition; but the sense of "psychosis" is obscure. And after all, even if we are content not to look for justification, it is this same question that is crucial to the difference between Soviet psychiatrists and others, over the use of compulsory treatment in the Soviet Union (para 8 above). The sense of "psychosis" however, is indeed obscure, and the definitions of the term proposed in the literature are correspondingly diverse. Nonetheless, they fall broadly into those

categories that are employed elsewhere in the literature for the definition of "illness" generally, and are subject therefore to the criticisms that we have considered in more detail in previous sections. Thus, there are those that rely on and assume, rather than making explicit, the sense of the term. Definitions in terms of causes, for example, (cf., II:2;3, III:2A;3), such as Jasper's, 1913, reliance on some underlying "process"; and a great many logically similar definitions in the psycho-analytic literature, reviewed by Laplanche and Pontalis (1973); or by listing particular well-recognised psychotic conditions (cf., III:2B;), e.g. Wing (1978). Similarly, there are those that are over inclusive, e.g. not being "open to rational persuasion", Glover (1970) - "irrationality" is a synonym for "madness" in the Shorter Oxford English Dictionary, but not all irrationality is constitutive of "illness", cf., pain as constitutive of illness, III:2B; others that appear to be tautological (cf., II:2;6), e.g. Glover (1970), goes on to describe the phenomena of psychosis as showing "... abnormal impairment... (of).... reasoning abilities"; and many others that are simply obscure, e.g. in terms of loss of "insight", or of inadequate "contact with reality" - the International Classification of Disease (1978), employs both these notions in distinguishing "psychosis from "neurosis", and then defines them (with a tautology which is

here legitimate since they are both assumed to be disease categories) as confusing "morbid subjective experiences and fantasies with external reality".

13. So apparently intractable is the notion of "psychosis", that some authors (e.g. Wing, 1978) have deplored its continued currency. The same authors, however, generally admit that the notion is one that we do not, and so presumably cannot, manage without. This is the reluctant conclusion also in the International Classification of Disease (1979) in which the psychoses, organic and functional, are distinguished as a principle category of disease from all other forms of mental illness. "Psychosis" then, like so many other terms, is difficult to define, but it remains current because it remains useful. And indeed, its particular utility is indicated by the very definitions of the term proposed in the literature. For these definitions, although in different ways question-begging, are similar in that they seem to beg the particular ethical implications of the term. "Irrationality", "impaired reasoning abilities", "loss of insight", "lack of reality testing", and the like, all hint at some failure of judgement; which, as we have seen (para 11 above), would justify the assumption that a patient's interests are not properly represented by what he wants. Wing (1978) indeed, makes this explicit; for he

concludes his review of the definitions of "psychosis" in the literature by stating that he will use : the term mainly to refer to one or more of the recognised psychotic conditions (para 12 above), but otherwise ... "only to describe a grossly abnormal mental condition, in which the affected person's capacity for responsible judgement is obviously disturbed". But it is the particular sense in which the "capacity for responsible judgement is obviously disturbed" as constitutive of a "grossly abnormal mental condition", that is at issue. And it is at issue precisely because, as we have seen, it is not "obvious" at all.

14. In the present study, we have approached the question of definition by considering what is involved in ordinary use in taking different kinds of phenomena, both mental and physical, to be constitutive of "illness". The term "psychosis", however, is currently employed as a generic term for a group of conditions that are characterised by the presence of at least one of three distinct kinds of phenomena - delusions, hallucinations, and certain peculiarities in the form of thought. The fact that conditions so characterised should be grouped together, suggests that these three phenomena (as constitutive of "illness") are similar in some logically important respect. And the identification of this similarity presumably would go some way towards an interpretation

of the sense of "psychosis" itself. Each of these phenomena, however, is associated with conceptual difficulties in its own right. Hence, attempts to extract their logically relevant common property, tend to issue in the obscurities of "loss of insight", "lack of reality testing", and the like, that we noted in paragraph 12 above. Rather than comparing these phenomena therefore, we shall examine one of them in detail, the phenomenon of "delusion".

15. Delusions have long been regarded as central to the phenomenology of "madness". Indeed, although the distinction between delusions and hallucinations was not consistently recognised in clinical practice until Esquirol in the nineteenth century, it was first noted by Asclepiades in the first century B.C. (Zilborg and Henry, 1941). In modern clinical practice, delusions are recognised in each of the functional psychoses, and are the defining characteristic of those designated "paranoid psychoses". Furthermore, they are, like the psychotic conditions that are partially characterised by them, reliably identifiable - some twenty-three distinct kinds of delusion are described in the Glossary to Wing's standardised Mental State examination (Wing et al., 1974). And they are commonly important in generating the particular ethical implications associated with "psychosis" generally. Indeed, the

paradigm case of these implications, is perhaps the suicidal patient whose self-destructive intentions are founded on some delusional belief. It is this kind of patient, for example, that Wing (1978) regards as most self-evidently imposing on the doctor an obligation to compulsory treatment.

16. The notion of "delusion", however, is unlike its parent notion "psychosis", in that it is one that doctors are by and large comfortable with. Indeed, those who would abandon the use of "psychosis" altogether, commonly advocate the retention of "delusion" or of conditions defined by the presence of delusions, in partial substitution (e.g. Butler, 1975; Wing, 1978). For, it is supposed, not only are delusions reliably identified by doctors, but doctors can give a good account of what they mean by "delusion". Delusional beliefs, this account might run, although largely stereotyped, vary in content; but they share certain common characteristics. That is to say, such beliefs are false and fixed (*vide infra*). Certain fixed false beliefs are however culturally determined (a belief in witchcraft among primitive people is the standard example), and these (consistently with the distinction between "illness" as "something wrong" with someone, and things that are done or happen to them) are not recognised clinically as delusions. Hence the

conventional textbook definition of a "clinical delusion" (viz., of a delusion that is taken to be constitutive of psychotic illness), is generally along the lines of "a false belief that is incorrigible, i.e. not susceptible to the ordinary processes of reasoning and appeal to evidence, and that would not normally be held by people of the same cultural background as the patient." Similar definitions, furthermore, are adopted with only minor reservations, in philosophical accounts of clinical delusions. Glover (1970) and Flew (1973), for example, both develop accounts along these lines; though both authors, in order to exclude eccentricities of belief and political beliefs respectively, limit the category of "clinical delusion" to severe delusions, i.e. beliefs that are held despite "overwhelming evidence" against them (Glover, 1970), that "really are without foundation", or that "march well outside the undemarcated frontier of ordinarily human cognitive fallibility" (Flew, 1973).

17. Definitions of "delusion" along these lines are on the whole appealing to doctors because they seem to accord well with the phenomena they recognise as delusions in practice. They have, however, a variety of other attractions. In the first

place, they are apparently value-free. Here is the patient; he has this belief which is false; he will not change his belief despite "overwhelming evidence" against it; and such beliefs are not current in the society from which he comes. Secondly, it may be said, the definition is not in terms merely of social deviance, since the "falseness" of the belief fixes the direction of deviance that is to be regarded as morbid. The definition therefore avoids the most obvious objection to value-free definitions of "illness" generally (II:2;5), and excludes political, aesthetic and even scientific beliefs that are merely socially unusual. Thirdly, although apparently value-free, such definitions would seem to provide for the evaluative element in the meaning of "illness" in so far as such an element is generally regarded as necessary. For a delusion, in being a false belief, will generally be one that the patient would be better off without; so that the diagnosis carries a negative evaluation by ordinary if not by strict implication (Quinton, 1980, in an open lecture, suggested that the falseness of delusional beliefs might actually provide for a negative evaluation that was strictly implied by delusions as constitutive of "illness"). Fourthly, such definitions would seem to provide for a link between "delusions" and the common identification of "illness" with "dysfunction"; the belief being false and fixed, the patient's reasoning powers may

be regarded as impaired, or not working properly; thus both Glover (1970) and Flew (1973), link delusions as constitutive of "illness" with an interpretation of "illness" in terms of "incapacity" or "failure of function". Fifthly, and most importantly perhaps, such definitions seem to explain and so to justify the special ethical implications of "psychosis"; for, in that a delusion is a false belief, it is harmful; in that it is fixed, it is constitutive of "illness", and of "illness" in which the patient's reasoning abilities are impaired. Hence, the patient's best interests may be served by treatment, even though treatment is not what the patient wants.

18. We arrive then, without too much difficulty, at a definition of "clinical delusion" that appears to correspond with those delusions recognised by doctors as constitutive of "something wrong"; a definition that is accepted, in its essentials, by philosophers; and that, in being descriptive in form, offers considerable face-value advantage for the development of psychological medicine as a scientific discipline. There are, however, difficulties. Some of these are of a broadly epistemological kind; the Cartesian doubt, for example; is it the patient or the doctor whose belief is false? - after all, to the patient, the evidence against his belief is not "overwhelming" (Glover, 1970, para 16 above); and what counts as a

belief that is "really.....without foundation" (Flew, 1973, para 16 above), is (tautologically) what counts as a delusion. We need not, however, dig as deep as this. For the definition is defective in a respect which is both more self-evident and more fundamental, in that delusions are not necessarily false beliefs at all. The standard example of this, in clinical practice, occurs in the Othello syndrome, a paranoid psychosis characterised by a single, though highly elaborated delusional belief that the patient's sexual partner is or has been unfaithful; which belief, if not concordant with fact initially, is so destructive in its effects, that it is commonly self-fulfilling. But in either event, as has been well-recognised for many years (Vauhkonen, 1968), it is not the falseness of the belief as such that identifies it clinically as a delusion. It may be false, and commonly it is false, but it is not necessarily so.

19. The Othello syndrome is not uncommon in clinical practice, and it is important in that it is one of the few psychiatric conditions that is associated with a statistically increased risk of homicide (Enoch et al., 1967). Hence, patients with so-called "delusional jealousy" are properly treated against their wishes where necessary, though generally in the interests of third parties. The logical

point, however, that delusions as constitutive of illness are not necessarily false beliefs, is made more arrestingly by those occasional paranoid patients whose delusional belief is that they are mad or mentally ill. One such patient was seen recently in Oxford, following a suicide attempt (Skegg, 1978). The patient had tried to kill herself because, she said, she was "mentally ill", and people who are mentally ill "get put away". She was seen by three psychiatrists separately in different contexts, each of whom confidently identified her belief that she was mentally ill as a delusion; and each of whom, on the strength of this, would have regarded themselves as under an obligation to the patient to treat her against her wishes had there been a continuing risk of suicide. In the event, she accepted ordinary reassurance that people who are mentally ill do not get "put away", and, although she refused further contact with the psychiatric services, the risk of harm to herself or others was not considered sufficient to warrant the use of compulsory treatment. Nonetheless, she remained convinced that she was mentally ill; and by the test of competent clinical practice, she was, for she was deluded. But at least in this particular case it could not have been the falseness of the patient's belief that led three independent psychiatrists to identify it as a delusion. Indeed, if the question of the falseness

of the belief had been in their minds, and if they had regarded clinical delusions as false beliefs, they would have been faced with an antimony. If they had decided the belief was false, they could have regarded it as a delusion, and so diagnosed the patient as mentally ill; but this diagnosis would have invalidated the original identification of the patient's belief as a false belief, and so would have been self-denying. Similarly, if they had decided the belief was true, they could have regarded it as a normal belief, and so concluded that the patient was not mentally ill; but this conclusion would have invalidated the original identification of the patient's belief as a true belief, and so would have been self-denying also.

20. That delusions are not to be defined as false beliefs, although well attested clinically, is a conclusion that might well arouse resistance: among doctors, because most clinical delusions are false beliefs; among philosophers, because it would seem to fly in the face of ordinary use. The Shorter Oxford English Dictionary, for example, defines "delusion" as ... "a fixed, false opinion with regard to objective things, especially as a form of mental derangement"; and early in Glover's (1970) discussion of the concept, he quotes J.L. Austin

(in *Sense and Sensibilia*, 1962) as distinguishing "delusions" from "illusions" as being "totally unreal". This latter objection, furthermore, may be reinforced by the observation that to fly in the face of ordinary use in this way, may seem to be to abandon the one sure defence against the possible abuse of medical authority. Thus, Flew (1973) regards... "the requirement of erroneousness... (as possibly the) ... only restriction on the content of delusions...", of which "only peculiarly flagrant kinds can serve as criteria (of mental disease)"; hence, he says, referring specifically to political beliefs, "It is wrong ... to take even an erroneous belief if not wholly indefensible as the criterion of the presence of mental disease". Neither Flew (1973) nor Glover (1970) seem to be aware that true beliefs may be identified as delusions in clinical practice. But if this were brought to their attention, possibly they would argue that this is simply bad practice; either because it is mistaken (Glover), or because it is actually dangerous (Flew). This, however, would be to miss the point. For it would provide no explanation for why such beliefs are recognised as delusions; and no account therefore of the properties of those beliefs generally that are constitutive of "illness". It may properly be argued, of course, that it is misleading to call true beliefs "delusions"; and, certainly, some less misleading term, such as "morbid beliefs", would be

useful. We could then say that most morbid beliefs are delusions, and severe delusions at that, but not all morbid beliefs are delusions; hence, any proposal to confine the category of "morbid beliefs" to delusions, must first provide an account of the defining properties of "morbid beliefs" generally.

22. Still, it may be said, we are dealing in somewhat rarefied cases. Most delusions surely, are contrary to the facts, and in clinical practice, obviously so. Delusions of mental illnesses are an oddity; of some logical interest possibly, but a rarity in clinical practice: and even delusional jealousy is commonly (though admittedly far from generally) associated with other unequivocally morbid phenomena. There is, however, a further twist to the story that brings us firmly back to the commonplace of everyday clinical practice. For delusional beliefs, as constitutive of "illness", are commonly not beliefs as to matters of fact at all, but beliefs as to matters of value. Such beliefs, therefore, cannot be recognised as "morbid beliefs" simply on the grounds that they are counterfactual. And beliefs of this kind are not only common in clinical practice, they are commonly crucial to the special ethical implications of "psychotic illness". Thus, the suicidal psychotic depressive (mentioned previously, para 15), may hold the delusional belief that, as a matter of

fact, he killed his children; and if he believes this, his view of his own worth, his right to live, his future prospects, and the like, may all be so unhappy as to warrant suicide. Equally, however, he may hold some quite normal factual belief in relation to his family, such as that he forgot on some particular occasion to hand out the children's pocket money; but this he believes to have been a profoundly wicked omission, a sign of his own depravity, and a clear indication that his family would be better off if he were dead - all of which beliefs would conventionally be regarded as delusional beliefs. In the former case, the delusional belief is a belief as to the facts, and facts that in most cases are readily falsified (to the satisfaction of everyone but the patient - his children, present before him, he may regard merely as imposters, a phenomenon which may constitute a paranoid condition in its own right, the Capgras Syndrome, Enoch et al., 1967; cf. para 18 above). But in the latter, it is not the facts that are at issue, but the patient's evaluation of them, and the further value judgements that flow from this initial evaluation.

22. "Morbid beliefs" then are not sufficiently characterised as "severe delusions" even though morbid beliefs commonly are severe delusions. And

at first glance, this may seem to accord well with the general conclusion of the present study, that "illness" is a value term. For if "morbid beliefs" are not just severe delusions, the text-book definition of them (i.e. of "clinical delusions"), together with its exclusively descriptive connotations (paras 16 and 17 above), clearly fails. Equally however, "morbid beliefs" are not to be characterised simply as negatively evaluated beliefs. Beliefs are evaluated, positively and negatively, and the values we place on them, for many kinds of belief at least, are related only partly to their truth or falsehood - we speak, for example, of "the sort of thing one ought to believe", of "what a dreadful thing to believe about him", and of wishing "I could believe that". And "morbid beliefs", that is "beliefs as constitutive of illness", are indeed negatively evaluated beliefs. But they are not simply negative evaluated beliefs. Furthermore, although this, as it stands, is also consistent with our previous conclusions (e.g. II:4, III:2A), the way in which beliefs as constitutive of "illness" are negatively evaluated, presents a particular puzzle where the beliefs in question are beliefs as to value. For what is involved here is not that the patient's beliefs are different from the doctor's beliefs, or even from the beliefs of society.

As we have seen (para 6 above), where there is a discrepancy of this sort, the Hippocratic obligation is normally governed by the patient's views. Rather it is that the patient's values are simply discounted as "real" values at all. And this indeed, is something of an ethical anomaly - for normally, however idiosyncratic, and however repellent, may be someone's values, they are respected in their own right so long as they do not impinge on others; and the logical freedom on the possible content of a value judgement (that anything may logically be positively or negatively evaluated, however contingently unlike some value judgements may be), is a corner stone of much ethical theory (e.g. Hare, 1952). But in the case of psychotic illness, beliefs as to value are actually set aside as evaluations; in taking such beliefs to be morbid beliefs, they are actually denied the status of value judgements.

23. Delusions then, in the experience of clinical practice, present at least two philosophical anomalies: an epistemological anomaly, viz., beliefs as to matters of fact that are correct but are taken to be delusions; and an ethical anomaly, viz., beliefs as to matters of value which are denied the status, and hence the ordinary logical properties, of evaluations. Both kinds of belief, that is to say, in being taken to be morbid beliefs, are

discounted as "true" beliefs; but the grounds for discounting them are obscure. We should not therefore, expect any very ready or complete philosophical interpretation of the properties of morbid beliefs. Nonetheless, the two sides to the "delusional coin", fact and value, and the complementary conceptual difficulties presented by them, does suggest an approach to an explanation for the particular ethical implications of "psychosis"; an approach, which, as we shall see, is consistent with the interpretation of "illness" developed in the present study. We will outline this approach in the remaining paragraphs of this section.

24. The modern clinical notion of "psychosis", we have suggested (paras 1-3 above), corresponds with the ordinary notion of "madness" or "insanity", in that it carries particular ethical implications (paras 4-6), which though widely and firmly acknowledged, are obscure and contentious (paras 7-9). Attempts to justify these implications lead to analytical enquiries since they have their origin in the sense of "psychosis" itself (paras 10-12). Definitions of "psychosis" in the literature however, vary widely; it is recognised that the notion is constituted by disturbance of reason, and that it is this disturbance

that justifies its particular ethical implications - but the particular kind of disturbance of reason that is involved remains obscure (para 13). The tendency among philosophers has been to examine the notion, with "clinical delusions" mainly in mind, in terms of the cognitive aspects of the sense of "reason" - in terms of knowledge, and the capacity to do things with it; hence Glover's emphasis on "overwhelming evidence", and Flew's reference to "cognitive fallibility" (para 16). This approach fails essentially on the point that morbid beliefs are not simply false beliefs (para 18-21). There is, however, a different aspect of the sense of "reason", that in which we speak of our reasons for doing things. And reasons in this sense, may, like morbid beliefs, be expressed either as beliefs as to fact or as beliefs as to value. If, for example, I am driving North from London on the M1 motorway, my reason for so doing could be given in terms either of the fact that Doncaster is North of London on that motorway, or of some expression of value such as that I want/ought/need to go to Doncaster. And indeed, in ordinary use, a satisfactory explanation for what one is doing in terms of one's reasons, will sometimes take the form of a reference to fact and sometimes of an expression of value, depending on context.

25. There is then, a suggestive correlation between "morbid beliefs" and "reasons for action"; the suggestion being that beliefs are morbid, in the sense required for "psychosis", where they fail as reasons in this particular aspect of the sense of "reason". A full vindication of this suggestion would require a complete account of how beliefs constitute reasons for action, and of the ways in which they may fail to do so. Four related points will be offered in place of this larger exercise. Firstly, reasons for action, although expressed generally either as beliefs as to matters of fact or as beliefs as to matters of value, only count as reasons if, in giving one, the other is implied, and vice versa. Thus, to return to the example in the preceding paragraph, my belief that Doncaster is North of London on the M1 motorway, would not count as a reason for driving North from London unless going to Doncaster was positively evaluated by me - i.e. unless I wanted, felt I ought, or needed to go to Doncaster. Similarly, that I wanted, felt I ought or needed to go to Doncaster, would not count as a reason for driving up the M1 motorway, unless I believed that Doncaster lay North of London on that road. In most contexts, either the value to me of what I am doing, or my beliefs as to fact, are self-evident; hence an explanation in terms of reasons is, as we have said, in general

sufficiently expressed in terms of whichever element is not self-evident. But both are necessary; hence, if giving one seems insufficient, if either my beliefs as to fact or my values do not sufficiently explain what I am doing, the appropriate move by way of explanation, is to make the other explicit. The "reason" even so, may not work, of course; and so the process of explanation may proceed further, by way of a progressive unpacking of my beliefs as to fact, and of my values. And, to come to our second point, it is some such process that seems to be involved in attempts in the clinical literature to characterise delusions. For those clinicians who have taken seriously the observation that morbid beliefs are not necessarily false beliefs, identify beliefs as morbid by some incongruity in what they "mean to" the patient, in the intensity of the patient's "reaction" (Shepherd, 1961), or of their related "behaviour" (Vauhkonen, 1968). These authors, that is to say, appear to be drawing on the elements of explanation that occur normally in giving reasons for action, and which, in respect of morbid beliefs, are identified as not working as they should.

26. There are then, clear hints in the clinical literature, from observations of "morbid beliefs" themselves, that the kind of "reason" that is taken to be defective in "psychosis", is "reason"

as in "reasons for action". But if this is so, our third point follows, viz., that we would seem to have the basis for a reconciliation of "psychosis" to the interpretation of "illness" developed in the present study. For the logical origin of "illness" has been identified in the experience of "action failure"; but if the failure of reason that is involved in "psychosis" is a failure of "reasons for action", it is a small step to the supposition that in "psychosis" there is a failure or breakdown in the notion of "action" itself. After all, "action" is distinguished from other "doings" partly by "intention" (II:3 ; 3); and "intentions" and "reasons" are very closely related conceptually - indeed, in so far as an intention in doing something is equivalent to a reason for doing it, much that we have discussed in previous sections in terms of "intentions" could have been discussed in terms of "reasons". And if this move, viz., from defective reasons for action as constitutive of "psychosis", to an assimilation of "psychosis" to an interpretation of "illness" generally in terms of "action failure", is prima facie reasonable, a further reasonable step would provide in principle for the particular ethical implications of the term. That is to say, given the close conceptual link between "action" and evaluation (III:2A;18), if "psychosis" implies "defective action",

there is scope for the notion to carry unusual ethical implications. Our fourth point then, is that a conceptual link between "psychosis" and "action" would be the kind of link within which an explanation for the particular ethical implications of the term might be found.

27. This last point is perhaps made more plainly in respect of the special status of "psychosis" as an excuse in law. This status constitutes a further particular ethical property of the notion, which is not as prominent in everyday clinical practice as the obligation to compulsory treatment (and hence has not been given detailed attention in the present section), but which has been more widely discussed in the literature. This discussion covers much of the ground that we have covered in respect of the obligation to compulsory treatment, and it will therefore bear brief review by way of a concluding summary. Thus, "illness" generally mitigates, and is sometimes an excuse; but "psychosis" is an important and central case of illness as an excuse in law. It has indeed, been recognised as such since classical times; and even in classical times it was identified as a special excuse, distinct from other categories of excuse (e.g. by Aristotle, *Nicomachean Ethics*, Book 3; Ackrill, 1973). Nonetheless,

just why "psychosis" should be an excuse, has been endlessly debated (Walker, 1968); that the psychotic's reason is disturbed is evident enough, but in what sense has not been clear. Certainly the defect is not merely a cognitive defect - this was the central objection to the M'Naghten rules, for example (Hart, 1968). But whatever its origin, central to the special status of "psychosis" as an excuse in law, is the phenomenon of delusion - in the Butler report (Butler, 1975), for example, three of the five phenomenological criteria for the "special verdict" are delusions (the remaining two phenomena being characteristic of organic psychotic states). But the operation even of delusions in this respect is obscure - for generally it is accepted that a delusional belief (e.g. of persecution) excuses in law, even where the same belief as a non-delusional belief would not do so (Walker, 1968). Sometimes this kind of case is assimilated to that of an "irresistible impulse"; but there is clinically no suggestion that the psychotic's capacity to resist is impaired - in other mental conditions (obsessive - compulsive states, psychopathy, and kleptomania, for example) it may be, but then the status of these conditions as excuses in law, is considerably less well established than that of the psychoses. A more convincing explanation therefore, has been that the defect of reason that characterises

psychotic illness implies that what the psychotic "does" cannot be construed as his "action" in that sense of "intentional action" that is required for legal culpability - this is essentially the conclusion that is reached, for example, by Flew (1973), Glover (1970) and Boorse (1975). It is then, "psychosis" as "action failure" that appears to lie behind its status as an excuse in law, just as it appears to lie behind the obligation to compulsory treatment that is implied by the notion in other contexts.

28. This conclusion, baldly stated, may seem to imply that the interpretation of "psychosis" developed in the present study is little different from that proposed elsewhere. Certainly, as have just noted, the identification of its special ethical properties in a deficiency or failure of "intentional action", is similar to other accounts. In the present study, however, we have reached this identification by a route that offers certain advantages over more conventional approaches. The conventional approach first identifies "illness" and "dysfunction"; "psychosis" is then interpreted as a particular form of "dysfunction" over which, as over other "dysfunctions" we have no control, and which therefore, are outside our sphere of intentional action. But there are at least two difficulties with this account. In the first place, it is far from clear

what "function" is disturbed in "psychotic illness"- it is not, as we have seen, the intellectual "reasoning" functions. And in the second place, partly because "psychosis" does not lend itself to interpretation in terms of "dysfunction", this approach inevitable leads to "psychosis" itself being discounted as a species of "mental illness" and/or as an "illness" with its particular ethical implications. But in both these latter respects, the interpretation of "psychosis" in terms of "dysfunction" runs counter to the facts - "psychosis" is the central and not a peripheral case of "mental illness"; and it is the paradigm case of "illness" as an excuse in law, and of illness as obligating to compulsory treatment. "Obsessional illness" is not, as Flew (1973) claims, the paradigm mental illness; nor, as Glover (1970) supposes, is "alcoholism" the clearest case of "illness" as an excuse. Boorse (1975), indeed, whose account of "illness" in terms of "dysfunction" we examined in Sections II:4 and III:3, openly admits that his interpretation gives him the wrong result in this respect. On his theory, as he puts it, "mental illness ... is beyond all hope of excuse"; and his theory therefore gives him a result which is contrary to the properties of the notion in ordinary use.

29. In the present study, "illness" and "dysfunction" have not been regarded as equivalent in meaning, and "dysfunction" has not been introduced into our interpretation of "psychosis". This interpretation, furthermore, provides in principle both for "psychosis" as a central form of "mental illness", and for the particular ethical implications of the term. For it suggests a very immediate conceptual link between "psychosis" as a particular form of illness, characterised by a defect of reason (for action), and "illness" itself, interpreted generally as deriving logically from the experience of action failure. And it is the very immediacy of this link that explains the particular strength of its ethical implications, in so far as these are related conceptually to the notion of "intentional action".

30. We seem therefore, in this outline of an interpretation of "psychosis", to be in the right general area. And if we have drawn back from further analysis, this is in proper recognition of the very considerable philosophical complexity of the difficulties presented by the notion. Such further analysis, of course, even if successfully completed, may not give all the answers that we might hope for. It may well be, for example, that there is no logical barrier to the Soviet notion

of "delusional reformism" (Block, 1981). But the conditions for a belief to count as a morbid belief, should at least be clarified. And thereby, the credibility of such notions could be undermined; which surely it is not, either by an evidently false assimilation of "psychosis" to other kinds of morbid phenomena (especially cognitive phenomena); or by an artificial, if stipulative, restriction on the acceptable content of the notion by way of special pleading.

IV:5 IMPLICATIONS

1. Some, but not all, mental phenomena, where they are constitutive of "illness", are constitutive of illnesses ordinarily regarded as "mental illness" (III:5). In the present section we have examined a wide variety of these mental illnesses; some that are closely similar in their logical properties to illnesses ordinarily regarded as physical illness (viz., cognitive disorders, IV:2), and some that are different (viz., neuroses, IV:3A; addictions, IV:3B; and psychoses, IV:4). In each case however, the notion of "mental illness" has been interpreted consistently with the analysis of "illness" developed in Section III from examples of physical illness. Not only therefore, do the results of the present section support the analysis of Section III, but, under this analysis, there is no logical barrier to the use of "illness" in respect of any of the mental phenomena that we have now examined.

2. This conclusion is evident partly in the account that we have given of the similarities between "mental illness" and "physical illness". For these follow directly from the move by way of generalisation from Section III to Section IV - "action" being central to the analysis of "illness" in Section III; "action" itself being both bodily and mental (IV:2); and "mental illness" and "physical

illness" therefore being interpreted similarly as species of "illness". It is however, born out even more strongly by our account of the differences between "mental illness" and "physical illness". Thus, it is true that the principle difference between them consists in the greater prominence, in respect of "mental illness", of difficulties in clinical practice that are conceptual rather than practical in nature. But in each of the cases we have examined, the difficulty presented by the use of "illness" was found to derive not from the notion of "illness", but from the logical properties of the phenomena by which it was constituted - "anxiety neurosis" (IV:3A), from the variation in the criteria for "loss" and for other value judgements as they relate to anxiety; alcoholism (IV:3B), from the difficulty of attributing intentions (what we "really want") in respect of appetites (which are themselves expressed as "wants"); and "psychosis" (IV:4), in so far as it is illustrated by delusions, from the ethical significance of "action", and of the particular kind of "action-failure" that is implied by irrationality as constitutive of "illness".

3. It follows therefore, under our present analysis of "illness", that the conceptual difficulties presented by certain kinds of mental illness in clinical practice, no more prejudice the conceptual status of the use of "illness" in respect of these mental phenomena, than they prejudice the conceptual status of the phenomena themselves. And indeed,

that "mental illness" in being contentious in application, faithfully reflects the properties of the phenomena by which it is constituted - just as does "physical illness" in being uncontentious. By the same token, then, our analysis, in moving by way of generalisation from "physical illness" to "mental illness", has done justice equally to the similarities and to the differences between them, thus satisfying the principle requirement settled at the end of Section I.

V CONCLUDING IMPLICATIONS

SUMMARY: The implications of the results of the present study are summarised with particular reference to the expectations outlined in Section I.

1. The proper functions of scepticism in philosophy, as Hamlyn (1970), has remarked, are to provoke doubt, without which philosophical enquiry itself would not get under way, and to provide a foil against which philosophical theories are most decisively tested. Scepticism about "mental illness" has served both these functions. We have not, however, sought directly either to support or to discount the sceptical attack on "mental illness". Indeed, it was the remarkable similarities between the arguments of proponents and opponents of "mental illness" in the literature, that suggested (in Section I) the form of our present analysis. Nonetheless, we have commented at various points on the views of both sides to this debate. And these comments we may now draw together, partly by way of summary, and partly by way of indicating the implications for clinical medicine of the analysis of "illness" that we have proposed.

2. The strongest form of the sceptical attack on "mental illness" is that the notion itself is in some way logically unsound. The arguments against this claim are of three main kinds. Firstly, there are arguments against its assumptions: there is no justification for supposing that simply because "mental illness" is different from "physical illness", it is a derivative of "physical illness" (I); nor indeed, that, because "mental illness" is more contentious and more overtly evaluative, than "physical illness", it is a logically weakened derivative (II:2/3 and II:4 respectively). Secondly, the claim can be challenged in respect of its scope: since "physical illness" is commonly constituted by mental rather than physical phenomena, scepticism about "mental illness" must be understood as being scepticism about "illness" constituted by certain kinds of mental phenomena, rather than scepticism about "illness" constituted by mental phenomena as such (III:5); and many illnesses ordinarily regarded as "mental illnesses" are not in fact subject to sceptical attack (IV:2). Thirdly, one may challenge the claim in respect of its conclusions: the conceptual difficulties presented by certain kinds of "mental illness" (both in diagnosis and treatment, which difficulties together are the main component of the "differences" between "mental

illness" and "physical illness", IV:1), are derived from the properties of the phenomena by which these kinds of illness are constituted (IV:3 and IV:4) - so that "mental illness", in faithfully reflecting these properties, is endorsed logically rather than prejudiced by them (IV:5). At best, therefore, the sceptical claim would have to be reduced to the merely contingent claim that nothing ever is mental illness - a claim which is rendered implausible by the fact that the most common sceptical interpretation of the phenomena ordinarily regarded as mental illness (viz., that they are "problems of living",) relies on one of the two distinctions by which "illness" itself is defined (IV:3A). To paraphrase Szasz then, "mental illness is not a myth".

3. But if our results do not support the opponents of "mental illness", they do not support its proponents either. The issue between them turns, as we saw in Section 1, on the significance of the similarities and differences between "mental illness" and "physical illness". Therefore, in "doing justice" equally to these similarities and differences (IV:5), if we have nullified the arguments of one side in the debate, we have nullified the arguments of the other side also. Thus, while our results suggest that "mental illness"

and "physical illness" are equally good specimens of "illness" logically, they actually support the view that there are important logical differences between them. And indeed, in identifying these differences mainly in the evaluative element in the meaning of "illness", the sceptical position is at least partly upheld. For, in explaining the origin of the more overtly evaluative properties of "mental illness" in the properties of the phenomena by which it is constituted, we have shown "mental illness" itself to be necessarily a more overtly evaluative notion than "physical illness". That is to say, its more overtly evaluative properties are built into the very logical structure of the notion, and are not a product of some inadequacy in our present understanding of it. And attempts therefore, by the proponents of "mental illness", to suggest that it is, in this respect, just like "physical illness", or that with a little clear thinking it could be seen to be so, are wholly mistaken.

4. There is however, a more positive side to this for conventional medicine. For in making explicit rather than suppressing the evaluative element in the meaning of "illness", we have clarified rather than obscured this element, and

hence clarified rather than obscured the factual element also (II:4). In particular, in deriving "disease" from "illness", rather than treating "illness" as a non-technical and unscientific appendage to "disease" (III:4), the whole structure of scientific concepts that have proved so productive in relation to physical illness, have been shown to be available in principle to mental illness as well (IV:2). There may be therefore good practical reasons for restricting, as Wing (1978), would have us restrict, the scientific study of mental illness to those mental illnesses that are most like physical illnesses - it may be, for example, that it is these mental illnesses that are most likely to be susceptible to the scientific techniques of investigation that are presently available to us. But there are no good reasons of principle. And to suppose that there are, is mistakenly to restrict the potential scope of scientific enquiry; which, as we observed in Section I, could only impede the future development of scientific medicine itself.

5. Analysis then, although concerned with the logical structure of medicine, may contribute in important respects to its development as a scientific discipline. As against this, however,

as we anticipated also in Section I, the results of analysis may seem to increase rather than diminish the burdens of clinical practice. Thus, in the first place, the largely establishment view that "mental illness" could and should be just like "physical illness", has been found to be an over simple response to the difficulties presented by mental illness in clinical practice; and therefore to be no more satisfactory as a basis for dealing with these difficulties, than the largely anti-establishment response, that "mental illness" is a myth. But in the second place, the more complicated interpretation of these difficulties proposed in the present study, amounts to the identification of them as, or as deriving from, difficulties of a very general and intractable kind in our ordinary conceptual scheme. Hence, the substantive clinical questions "what counts as 'illness'?" and "what does 'illness' count for?", the questions which, as we put it in Section IV:1, lie either side of the factual issues in diagnosis and treatment, are not provided definitive solutions by our analysis. And this surely, must always be true, to some extent, of analyses that are narrowly linguistic rather than metaphysical in scope.

6. It could, of course, properly be said that this is no empty begging of philosophical questions. - for the identification of the true nature of the conceptual difficulties of clinical practice, albeit as instances of larger difficulties of a general philosophical kind, is at least a first step towards their solution. But there is, from the clinical point of view, small comfort in this. For, even if satisfactory answers were available for these "larger" philosophical questions, there is no guarantee that they would issue in determinate solutions to the difficulties experienced by doctors in clinical practice. And this indeed, would tend particularly to be so where these difficulties, as in the present study, are identified in the evaluative part of the meaning of "illness" itself. Indeed, the very recognition that "illness" is a value term, has the corollary that doctors cannot (in the logical, and hence the strongest sense of "cannot") practice medicine without making value judgements. They may individually avoid areas of practice in which the value judgements required of them are not contentious; but not corporately. And the burden of philosophical insight here, is that no accumulation of facts will substitute for the value judgements that are and must be made by individual doctors in coming to particular clinical decisions.

7. Even in this respect, however, analysis has not created a burden for clinical practice that was not there before; it has simply made its obligatory nature explicit. Indeed, this particular analytical insight is no more than the logical counterpart of the commonplace observation, that the practice of medicine is more than a merely scientific pursuit. And there is, after all, some advantage for conventional medicine in taking this observation seriously - for it greatly reduces the force of sceptical arguments against the concept of "mental illness"; at the very least, removing the confusion of conceptual difficulty and conceptual deficiency upon which these arguments mainly depend (I;9). But it remains true, nonetheless, that in so far as solutions to the conceptual problems of clinical practice are possible, they will depend on solutions to problems that are philosophical rather than practical in nature. And to this extent, analysis is no sinecure.

8. In reaching solutions to these difficulties however, medical practice should be no passive partner of philosophical enquiry. For precisely because the difficulties with which it is concerned are difficulties in the everyday practice of medicine, they should lend to philosophy an urgency in their consideration, that no merely arms length contemplation could enjoy. And given this urgency,

precisely because these difficulties are difficulties of a general philosophical nature, they should prompt, rather than merely wait upon, progress in philosophy itself. It may be, therefore, that there has been until recently little need for conceptual enquiry in medicine (I;1); but now that there is, medicine and philosophy should issue in hybrids of considerable vigour.

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