CHAPTER 2

Philosophical problems in mental health practice and research

Chapter contents

> It is a remarkable fact that philosophers, in a sense the experts on rationality, should have taken so little interest in irrationality.
>
> Anthony Quinton (1985)

Things have changed a lot since Anthony Quinton, a British philosopher, formerly at Oxford and then a member of the House of Lords, made this observation in a lecture to the Royal Institute of Philosophy (Quinton, 1985). Philosophers are nowadays actively interested in a wide range of topics from mental health practice and research. Conversely, mental health practitioners (including both professionals and users of services) are actively interested in a wide range of philosophical topics. Indeed, the explosive growth in cross-disciplinary contact in the last few years (see Reading Guide) has been as remarkable as the earlier long period of mutual neglect.

The years of neglect have left a legacy, though, in the form of a communication gap. Philosophers coming for the first time to a problem in mental health often lack the background knowledge, the first-hand 'craft' experience, to tap into the philosophically relevant aspects of mental health problems in a practically relevant way. Practitioners, on the other hand, coming to philosophy for the first time, often have little understanding of what philosophers do and of how they go about doing it.

Part I of this book is designed to throw a bridge across the communication gap between philosophy and mental health. In this chapter, we start the process of bridge-building with a look at the nature of philosophical problems in mental health. We examine how and where they arise, and the ways in which they differ from the empirical (or scientific) problems with which practitioners are usually more familiar.

Structure of the chapter

This chapter is divided into four sessions:

- *Session 1*: What is philosophy? What is psychiatry?
- *Session 2*: Fact, value, and the concept of mental disorder.
- *Session 3*: Antipsychiatry and the debate about mental illness.
- *Session 4*: The medical model (and beyond).

Session 1 introduces both sides, philosophers and practitioners, to the nature of philosophical problems in mental health. Then, in *Sessions 2–4*, we tackle what is perhaps the central philosophical problem in mental health, i.e. how the very *concept* of mental disorder should be understood. Session 2 sets out the terms of reference of the problem in the form of a conceptual 'map' of the key features of mental disorder. Session 3 looks at antipsychiatry and how this measures up to the need to explain the conceptual features of mental disorder. Session 4 repeats this process for pro-psychiatry.

Taking the results of Sessions 3 (antipsychiatry) and 4 (pro-psychiatry) together will give us a deeper understanding of the problem of how the concept of mental disorder is to be understood. Chapter 3 will build on this, filling out the details of the wide variety of mental disorders covered by the conceptual map of psychiatry introduced here in Session 2. This in turn will pave the way for an introduction to philosophical methods, the topic we will be taking up in Chapters 4 and 5.

Session 1 What is philosophy? What is psychiatry?

What philosophy is, is a problem with which philosophers themselves have been much concerned—there are whole books on the subject, and many introductions to philosophy start with a section on this question.

Psychiatrists have not in general been much concerned with what psychiatry is. Most textbooks make some simple opening statement about it being a branch of medicine concerned with disorders of the mind. Other groups, however, psychologists, mental health nurses, users of services, and carers, have often been critical of psychiatry's self-image as a branch of medicine. As we will see later in this chapter, they have adopted different, although not necessarily incompatible, models of mental health.

A clinical case history

So, there is a problem about what philosophy is; and there also is a problem about what psychiatry is. Let's start with an example.

EXERCISE 1 (20 minutes)

First, think of a problem case, preferably one where involuntary treatment was an issue. If you have practical experience of mental health, there may be a case known to you personally, either in a professional capacity or as a user of services. Any case will do: but write down brief details, covering the problem, how it was assessed (including the 'diagnosis'), management, and outcome. (Obviously, if you are working in a group, you need to be careful to anonymize the story to ensure confidentiality.) If you are a philosopher, or otherwise do not have access to a suitable case, here is an example . . .

Example case: Mr AB, Age 48, bank manager

Presented in casualty with low mood, biological symptoms of depression (he had been waking early and had lost weight), and a hypochondriacal delusion (that he had brain cancer). He had a past history of a serious suicide attempt. He had come to casualty complaining of pain in his face and asking for something to 'help him sleep'. He was diagnosed as suffering major depression but refused to stay in hospital for treatment. On an application from his wife, he was admitted as an involuntary patient under the Mental Health Act, 1983 (applicable at the time in England and Wales). He made a full recovery on antidepressant medication. At follow-up a few weeks later, he admitted that he had been planning to kill himself when he believed he had brain cancer and had been feeling so depressed.

(We will be returning to Mr AB's story several times in this and later sessions. It is described more fully in Fulford, 1989.)

Now, think about the problem presented by Mr AB when he was refusing treatment (or your own equivalent case). This is an 'everyday' clinical problem. But is it a *philosophical* problem?

As we will see, there are a number of ways in which Mr AB could be said to present a philosophical problem. Before going on, think about this for yourself:

1. list as many philosophical problems presented by Mr AB as you can think of, and
2. contrast these with the way his problem would ordinarily be formulated clinically.

Everyday clinical assessment

In everyday clinical practice, the assessment of a person such as Mr AB would be 'summed up' in a *diagnosis*, e.g. 'major depression', as in the vignette. This is based on a wide range of information derived from: (1) taking a 'clinical history' (from the patient and from 'other witnesses', e.g. Mrs AB); (2) from an examination of 'the *mental state*'; and (3) from a physical examination. We will be returning to this in Chapter 3. Briefly, the Mental State Examination (or MSE) is a structured review of the patient's appearance, behaviour, and speech, especially as these reflect their mental state. It also covers the form and content of their thoughts; their mood (happy, sad, etc.), beliefs (including delusions), and perceptions (including hallucinations); their 'cognitive functioning' (which in this context means orientation in time and for place and person; attention; short- and long-term memory; and general intellectual level, or IQ); and their insight into the problem. Detailed accounts of psychiatric assessment, including examination of the mental state, can be found in any of the textbooks listed in the reading guides to this chapter and to Chapter 3 (the introduction to psychopathology).

The large amount of information gathered about the patient, from the history, MSE, and physical examination, now has to be summarized and organized into what is called a *formulation*. A formulation sets out in note form the key information about the patient under four main headings:

1. *Differential diagnosis*: this covers (a) the patient's *symptoms* (the precise form of which may be important—we look at a number of particular delusions, hallucinations, and disorders of thinking in more detail in later sessions), and (b) the *pattern* of symptoms and the extent to which these fit the 'disease entities' or particular disorders defined in psychiatric classifications. A differential diagnosis takes the form of a list of possible diagnoses with a summary of the points from the clinical history, etc., for and against each of them. In Mr AB's case, the list would include not only major depression, but, e.g. atypical facial pain, and indeed, brain cancer.
2. *Aetiology*: the causal factors that may be operating, usually divided into predisposing, precipitating, maintaining and protective, i.e. strengths or positive factors.
3. *Treatment*: the management plan, building on the person's own strengths and resources to produce the particular combination of psychological, social, and physical interventions (e.g. antidepressant drugs), appropriate to the individual's needs, but also including (a) *explanation* (i.e. the understanding of the problem to which the practitioner has come with the patient), and (b) plans for *follow up*.
4. *Prognosis*: i.e. an estimate of the likely outcome.

Points arising: empirical and conceptual

The process of gathering and organizing all this information may be highly problematic in straightforwardly empirical (or fact-gathering) ways. In more technological areas of medicine, *most* of the problems of assessment are empirical. In primary care, though, and in mental health in particular, some of the most difficult problems arise not so much from disagreements about the *facts*, as from disagreements about how the facts should be *understood* or *interpreted*.

Mr AB: a clinical conceptual problem

This is well illustrated by Mr AB. Most psychiatrists reading the facts of his case (as in the vignette) think that it is obvious what should be done, i.e. that Mr AB should be treated as an involuntary patient under the relevant mental health legislation. Other groups, however, disagree with this, rejecting involuntary treatment on grounds of human freedom and dignity. We will be returning to involuntary treatment in detail later (in Part IV). The essential *clinical* difficulty with involuntary treatment, however, is not the facts but how the facts should be interpreted or understood. If we understand Mr AB's condition (defined by his sadness, beliefs, pain, etc.) to be a mental illness (or other form of mental *disorder*), then involuntary treatment may be appropriate in view of the risk of suicide. If we do *not* take his condition to be a mental illness, then involuntary treatment is *not* appropriate (though other *non*-medical preventive interventions may still be made, on, e.g. humanitarian or religious grounds).

So the critical clinical issue in Mr AB's case (and this is an *everyday* clinical case, remember) is not the facts but how the facts are interpreted. This is where philosophy comes in. Broadly speaking, where science is concerned with facts, philosophy is concerned with concepts, with the general framework of ideas within which facts have to be interpreted or understood.

No sharp divide

We will see later, especially in Part III, that this way of putting it suggests too sharp a divide: science is not, merely, fact-gathering, whatever some scientists may think; philosophy, similarly, cannot proceed in a fact-free world, whatever its pretensions in that direction. There are no 'theory-free facts': all concepts are contingent

(dependent on the way things are), even if only developmentally (i.e. in the way we come to grasp them). All the same, the distinction as formulated perhaps most clearly by the eighteenth century Prussian philosopher Immanuel Kant, between form (concepts) and content (facts), still serves well in many areas. (We return latter in detail in Part II.)

Philosophy and clinical cases

Where does this leave Mr AB? What is 'philosophical' about his problem? The term 'philosophy', understood as a concern with concepts, is used in three main ways, ranging from (1) one's overall '*Weltanschauung*', or scheme of life, through (2) various specific branches of philosophy (such as ethics), to (3) more detailed conceptual analytic concerns with clarifying meanings and implications. Mr AB can be understood as raising philosophical problems in all three senses of the term.

1. *Weltanschauung*. There is an issue of '*Weltanschauung*'. Should Mr AB be regarded as someone who is ill and, to this extent, not responsible? Or does he have a spiritual or moral problem? Many religions would not condone suicide even for someone who believes he has brain cancer. Issues of courage, of free will, come in. We all bring a general 'philosophy of life' of some kind to our understanding of human behaviour. Given Mr AB's story as described here, it is more (or less) natural to think of him as ill. However, suppose he had raped someone? Issues of responsibility are especially emotive in forensic psychiatry.
2. *Specific areas of philosophy*. Several philosophical disciplines are relevant to the clinical problem presented by Mr AB. At one level, the problem is *ethical*—the ethical problem is between Mr AB's right to autonomous choice and the responsibility of the doctor to use his skills with the patient's best interests in mind. (We will return to this in Part IV). But there is also an *epistemological* (or theory of knowledge) question at the heart of the case (is his belief *really* a delusion); a *jurisprudential* issue (of the legal grounds for taking Mr AB to be not responsible for his own choices, however foolish); there is a *phenomenological* issue (just how do we 'understand' Mr AB's experience, how should his mental states—his wishes, motives, and so forth—be properly described? This is an area to which Continental philosophy is especially relevant). There are also issues of a *political philosophical* kind. Michel Foucault, writing in the Continental tradition, argued on historical grounds that the incarceration of the mentally ill reflected the 'work ethic' of the industrial revolution and the need to preserve social order. This tension, between moral (or social) and medical interpretations of cases such as Mr AB, has a long history. So the *history* of *ideas* is important, as we explore in Part II. Finally, Mr AB's case also raises a range of deeper *metaphysical* issues: if he has a *mental* illness, how should we understand the relationship between mind and brain? (The mind–body problem is explored in detail later, in Part V.)
3. *Conceptual analysis*. At the heart of all these issues, though, as we saw a moment ago, is a conceptual problem, namely, just what is meant by saying that Mr AB is mentally ill. We will return to this in more detail in Part IV, where we will see that involuntary psychiatric treatment depends on two conditions being satisfied: the person concerned must be (1) at *risk* (to themselves or others), but also, (2) suffering from a *mental disorder*. In Mr AB's case, as noted in the vignette, the relevant legislation was the UK Mental Health Act, 1983: but there is similar legislation in most countries around the world. In all legislations, the second condition, that the person concerned is suffering from a mental disorder, is crucial (see, e.g. Fulford and Hope, 1996). Yet the key terms here, 'mental disorder', 'mental illness', and so on, are not defined legally.

Neglect of conceptual difficulties

So the law is not much help on the central conceptual issue raised by Mr AB. Surprisingly, perhaps, neither is psychiatry. Medical textbooks define particular mental disorders, but they rarely attempt to define what, in general, makes a disorder a *mental* disorder, let alone the still more general question of what makes a condition a *disorder* in the first place. A notable exception is the American Psychiatric Association's (APA) classification of mental disorders, the DSM; however, this explicitly precludes its use in medico-legal contexts (APA, 1994, pp. xxiii–xxiv). Thus, we can indeed map Mr AB's symptoms (early waking, weight loss, low mood) on to the criteria in the textbooks for 'major depression'. But this simply begs the question of why these 'symptoms' should be regarded *as* 'symptoms', and Mr AB's condition *as* a mental illness, and hence as a mental *disorder* as required by the Mental Health Act.

The scope of philosophy and mental health

Philosophy in all three senses of the term is therefore relevant to our understanding of Mr AB's case, and thus, by implication (his case being an *everyday* clinical case), to mental health generally.

In this book, it is with sense 2 (specific philosophical areas) and sense 3 (conceptual analysis) that we will be mainly concerned. This is because it is philosophy in these two senses of the term that allows joint work focused at a level of detail sufficient for effective interdisciplinary exchange: thus,

- *Conceptual analysis*. This provides the most general point of contact between psychiatry and philosophy, at least as practised in the Anglo-American tradition. The great philosopher–psychologist, William James, writing early in this century, described philosophy as '. . . an unusually stubborn effort to think clearly' (James, 1987, p296). It is the lack of clear meaning, the need for conceptual clarification, which is at the heart of psychiatry's need for philosophy.

- *Specific philosophical areas*. It is the problems in specific areas of philosophy, on the other hand, which are at the heart of philosophy's need for psychiatry. This is because, as in Mr AB's case, the practical problems of everyday research and practice in mental health provide concrete and specific instances of the metaphysical problems studied in general philosophy.

The *Weltanschauung* (sense 1 of 'philosophy', as above) is also important, however. So long as the mind-sets of philosophers and practitioners were incompatible, they could not 'see' their mutual dependence. It is the change in *Weltanschauung* in the decade since Anthony Quinton's observation (with which we started this chapter) that has allowed both sides, practitioners and philosophers, to recognize that far from ignoring each other, we are now on the brink of a partnership potentially as fruitful as the well-established partnership between clinical practice and science.

Reflection on the session and self-test questions

Run over the materials we have covered in this session, the clinical case history, of Mr AB; the 'points arising', as we called them, empirical and conceptual; and their implications for the scope of the interdisciplinary field of philosophy and psychiatry. What key points do you think should be taken from these materials?

We list a number of our own suggested key points at the end of the book. However, remember that as with all the exercises in this book, drawing on your own background experience and skills, you may spot very different key points from us. So, write your own ideas down first and then try answering the following questions:

1. With what kinds of disorders is psychiatry particularly concerned?
2. What is covered by a psychiatric diagnostic formulation?
3. How does the subject matter of philosophy differ from that of science?
4. What broad areas or kinds of philosophy are there?
5. What concepts are at the interface between philosophy and psychiatry?

Session 2 Fact, value, and the concept of mental disorder

In the first session in this chapter, we identified an important general point of contact between philosophy and mental health in the problems raised by the concept of mental disorder. In this session, we start to look at these problems in more detail.

The aim will be to set out more explicitly just what it is about mental disorder that makes it more problematic conceptually than bodily disorder. Gilbert Ryle, an Oxford philosopher writing in the 1940s and 50s, and the author of an important book on the philosophy of mind, *The Concept of Mind* (1949/1963), described this setting out process as mapping the 'logical geography'. We will come back to the importance of this in Chapter 4, when we consider philosophical methods. However, the basic idea is to get a picture of the *features shown by a given concept or set of concepts as they are actually used in a given area*, these being the features that a philosophical analysis of the meanings of the concepts in question must explain. This 'mapping out' process will prepare us for looking at two very different explanations of the meaning of mental disorder in the remaining two sessions in this chapter.

A conceptual map of mental disorder

In Exercise 2, then, we are going to start building up a map (a conceptual map, remember) of mental disorder. As we emphasized in Session 1, you will get a lot more out of this if you don't cheat; i.e. try the exercise for yourself *before* reading on.

EXERCISE 2 (20 minutes)

This is a two-stage exercise.

Stage 1 (15 minutes)

Write a list of mental disorders—Write down as many examples of the different main categories of mental disorder as you can think of. If you are working in a group, this exercise is best done in philosopher–practitioner pairs. If you are working on your own, a good way to 'brainstorm' a suitable list is to start with you own list, and then check through the relevant chapters and/or index of a textbook of psychiatry.

Stage 2 (5 minutes only)

Make a map—Reorganize your list to make a map showing the extent to which you think the different kinds of mental disorder are more or less like bodily disorders. In doing this, don't think too hard about just why a particular mental disorder is like or unlike a bodily disorder (we will be covering this in detail later in this part). Just make a quick 'guts-feel' global judgement of the extent to which you feel the mental disorder in question is 'like a disease'.

Now, look at the 'map' in Figure 2.1. There may well be differences between this map and yours. But the overall pattern people come up with is usually (though not invariably!) more or less the same.

For those not from a mental health background, the numbers on the map can be cross-referenced to the glossary of examples in Box 2.1. As noted above, we will be looking at the details of all these conditions in Chapter 3.

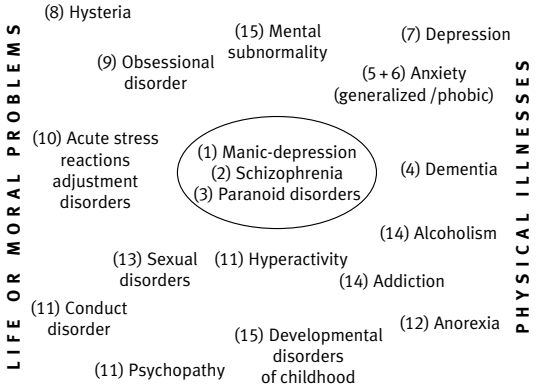

Fig. 2.1 A conceptual map of mental disorder. The different kinds of mental disorder can be set out schematically, as in this 'map'. Although not representing a well established classification of these disorders, the map illustrates a number of the features of the conceptual terrain of psychiatry which any theory of the meaning of mental illness must explain. The numbers refer to the illustrative case vignettes given in the accompanying glossary (Box 2.1). (Adapted from Fulford, K.W.M. (1993). Value, action, mental illness, and the law. In *Action and Value in Criminal Law* (ed. S. Shute, J. Gardner, and J. Horder). Oxford: Oxford University Press, pp. 279–310).

Box 2.1 A glossary of examples of mental disorder—brief definitions and examples of pyschological disorder

(*All cases based on real patients but with biographical details disguised. Further examples and details of psychopathology are given in chapter 3.*)

1. Manic-depressive illness

(a) Depressed type

Psychotic disorder with depressed mood. The psychoses are severe disorders typically with loss of insight shown characteristically by delusions, hallucinations, and certain forms of thought disorder (e.g. thought insertion—*see case* 2).

Mr SD, age 38—senior manager. Presented in casualty (with his wife) with a 3-week history of 'biological' symptoms of depression 'early waking, weight loss, fixed diurnal variation of mood' and delusions of guilt 'believed he caused the war in former Yugoslavia'. History of attempted suicide during previous similar episode. Denied that he was depressed but said he needed something to help him sleep.

(b) Manic type

Psychotic disorder with elevated mood.

Miss HM, age 25—novice nun. Brought by superiors for urgent out-patient appointment as they were unable to contain her bizarre and sexually disinhibited behaviour (running away from convent and soliciting 'for the Lord'). Showed pressure of speech (continuous talking), grandiose delusions (that her minor charities are saintly acts of 'great and enduring moral worth'), and auditory hallucinations (female voices telling her she is Mary Magdalene).

2. Schizophrenia

Psychotic disorder with specific delusions, hallucinations, and disorders of thought ('first-rank' symptoms), together with a large number of other disturbances, especially of affect and volition.

Mr. S, age 18—student. Emergency psychiatric admission from his college. Behaving oddly (found wandering, in bemused and agitated state). Complained that people were talking about him. Showed thought insertion (John Major 'using my brain for his thoughts') but no cognitive impairment (*see case 4*).

3. Paranoid disorders, e.g. Othello syndrome

Psychotic disorders with well-developed delusional symptoms (not necessarily of persecution) and little other pathology. In the Othello syndrome the paranoid system is built round delusions of infidelity.

Mr A, age 47—publican. Seen by general practitioner initially because his wife was depressed. However, Mr A complained of anxiety and impotence. GP suspected alcohol abuse. After some discussion, Mr A suddenly announced that 'the problem' was that his wife was 'a tart'. Once started, he went on at length about her infidelity, drawing on a wide range of evidence, some of it bizarre (that she washed their towels on a different day; pattern of cars parked in street had changed).

4. Dementia

Psychotic disorder with progressive impairment of 'cognitive' functions—namely memory, attention, orientation (time, place, person), and general IQ—caused by gross brain pathology, hence sometimes called 'organic psychosis'. Acute (and usually reversible) disturbances of cognitive functions occur in confusional states (e.g. after blow to the head, or with intoxication). Visual hallucinations are common.

Mrs GM, age 65—shopkeeper. Referred by general practitioner when her customers complained that she had started to forget their orders. Family confirmed she had become forgetful and at times seemed confused. She had been complaining of seeing rats in her storeroom but there was no evidence of these. Initially denied problem but on cognitive function testing unable, e.g. to recall a simple name and address after a gap of 5 minutes.

5. Anxiety disorder—generalized

Sustained periods of anxiety with associated bodily symptoms in absence of appropriate cause.

Mrs B, age 35—teacher. Presented to general practitioner complaining of a constant sense of anxiety for which she

could give no reason, developing over about 3 months. Had always been a worrier but coped well with a stressful job. Had difficulty getting to sleep and bodily symptoms (palpitation and difficulty swallowing).

6. Anxiety disorder-phobic

Pathological anxiety related to a specific object or situation and leading to avoidance.

Mrs RD, age 23—housewife. Visited by district nurse at home as she had failed to attend for postnatal follow-up. She explained that she had become afraid to go out because of a fear of thunder. This had been a lifelong fear but had become worse since she gave up work to have her baby. Even approaching the front door produced feelings of panic with bodily symptoms (palpitation, hyperventilation, tingling in her fingers).

7. Depression—non-psychotic

Pathological depression of mood without psychotic features.

Mr RJ, age 32—bricklayer. Presented to general practitioner complaining of feeling miserable and difficulty getting to sleep. For some months he had lost his enjoyment of life and tended to lie awake at night worrying about the future, even though he had no particular problems at present. Physical examination was normal and he had not lost weight.

8. Hysterical disorders

Physical symptoms (e.g. paralysis, blindness, memory loss) with psychological causes.

Miss HP, age 30—secretary. Admitted to neurology ward and transferred to psychiatry under protest. Unable to move right hand. No evidence of physical lesion. History of depression and self-injury.

9. Obsessive-compulsive disorder

Recurrent mental content (obsession) or behaviour (compulsion) typically recognized by patient to be irrational and resisted but unsuccessfully (like a bad case or getting a tune 'stuck in your head').

Mr OC, age 27—bank clerk. Three-year history of progressive slowness. Referred with recent depression and anxiety following suspension from work. Showed severe and progressive compulsive checking, which he saw as 'ridiculous', but was unable to stop.

10. Acute reaction to stress

Marked psychological reaction to sudden stressful stimulus. Adjustment disorders are corresponding reactions to more chronic situations, e.g. a grief reaction which becomes excessively extended. These disorders are in many respects the psychological counterpart of physical trauma or wounds.

Mr JB, age 55—doctor. Involved in serious car accident while returning from an emergency call-out late at night. No head injury. Was unable to recall the accident. Felt anxious, distressed, and unable to cope with his work for several days. Then developed a brief, self-limiting manic reaction.

11. Psychopathic personality disorder

Personality disorders differ from illnesses in being more or less fixed features of the way a person feels, thinks, or behaves. With psychopathy the disorder is manifested mainly in repeated delinquency. The conduct disorders of childhood have similar manifestations but are self-limiting. Hyperkinetic syndrome of childhood is pathological overactivity.

Mr PP, age 23—unemployed. Seen in casualty by duty psychiatrist. Brought in by girlfriend because he was threatening to kill a rival. Had been drinking. History of repeated criminal assaults. Promiscuous.

12. Anorexia nervosa

Pathological disorder of eating in which patient refuses to eat, may exercises excessively, and/or abuses laxatives. Self-induced vomiting is common. Typically perceive themselves as fat, despite extreme emaciation, together with physiological and other changes of starvation.

Miss AN, age 21—student. Four-year history of intermittent anorexia. Currently seriously underweight, exercising, and using laxatives; amenorrhoeic. Refusing admission on the grounds that she is 'too fat'.

13. Sexual disorders

These may involve (a) pathological changes in sexual drive and/or function, or (b) disorders of sexual-object choice (e.g. sadism, paedophilia).

Mr RP, age 24—postgraduate student. Attended student counselling service complaining of difficulty maintaining an erection. Had a steady girlfriend and normal sexual interest and drive. Struggling to finish his doctoral thesis.

14. Alcoholism and drug addiction

Abuse of alcohol or drugs which is out of the patient's control. There is often denial of the problem.

Mr AR, age 38—shopkeeper. Self-referral to general practitioner from Relate (marriage guidance counselling). Over several years had increased his alcohol consumption and was now drinking a bottle of spirits and several pints of beer

every day. Without a drink in the morning his hands shook. His wife was threatening to divorce him and he had lost many of his customers. However, he was ambivalent about the referral, arguing that he had the problem 'under control'.

15. Mental subnormality and developmental disorders of childhood

With mental subnormality there is pathologically low IQ together with varying degrees of emotional and behavioural abnormality persisting from birth. The developmental disorders of childhood include delays in reaching normal milestones, e.g. persistent urinary incontinence ('bed wetting'), delayed walking, talking, or reading.

Maps of the kind shown in Figure 2.1 can be used as Rylean 'logical geographies'. They incorporate a number of important features of the concept of mental disorder (as explored in the next exercise). Hence, any philosophical theory of mental disorder that purports to give us a better understanding of the *meaning* of mental disorder must explain at least these features. In this respect, these features (as set out in the 'Rylean' map) are like the data of a scientific theory—the better the theory, the more 'data' (the more features of the map) it will explain.

This is not to say that the theory must *endorse* these features. A philosophical theory of the meaning of mental disorder must explain, either why the concept of mental disorder *has* the features it has, or why it only *appears* to have these features. Either way, though, *some* theory of these features (as summarized in the map) is required.

Four features of the map of mental disorder

So, what are the features of 'mental disorder', set out in this way? We will be looking at four features in all, starting with, (1) *diversity*, and (2) variable conceptual *distance from bodily disorder*—these are the two features we concentrated on in Exercise 2. These two features lead, in turn, to two further features: (3) variable *status as illnesses*, especially in the extent to which a mental disorder is an excusing conditions in law, rendering the sufferer 'not responsible', and (4) variable *degree of value-ladenness*.

Start with your own ideas

We will be looking at each of these features in detail, in particular Feature 4, the value-ladenness of mental disorder. Before going on, however, it is important to think about them a bit further for yourself.

EXERCISE 3 (15 minutes)

Go back to your own map and the map in Figure 2.1. Think about the four features just listed:

1. What do they mean?
2. Are they really features of mental disorder?
3. Are they features specifically of mental disorder (i.e. more so than bodily disorder)?, and
4. Why do they matter?

Note: At this stage, you may feel you have no idea what we are talking about, what we mean, for example, by 'diversity' or 'conceptual distance': don't be put off! At this stage, this is all to the good. It makes it all the more important to think for yourself about these features of mental disorder before going on. Remember, this book is all about acquiring new skills through your own active engagement with the line of argument. It is not about passively acquiring other people's ideas.

We are now ready to look together at the first of the four features of the conceptual map of mental disorder, diversity.

Feature 1 of mental disorder: diversity

Diversity, straightforwardly, is the plain variety of mental disorder. At first glance it may seem odd to claim that diversity is a feature specifically of mental disorder. After all, if you flick through a *medical* textbook, you will find just as many different categories of disorder as there are mental disorders in a *psychiatry* textbook, and covering a wide range of systems (cardiovascular, gastrointestinal, etc.).

There is one important respect, though, in which mental disorders really are more diverse than bodily disorders, namely, in the form of their *symptoms*. The details of this will take us, later on in this part, into the whole question of the relationship between illness and disease. For now, though, the point is this. The symptoms of bodily disorders are largely confined to sensations (nausea, dizziness, bodily pains, etc.), movements (abnormal movements such as tics; or paralysis), and perceptions (especially failures of perception, such as blindness or deafness).

Symptoms of mental disorder, on the other hand, as the glossary in Box 2.1 indicates, although occurring in each of these categories, also include disturbances of emotion (anxiety, depression), volition ('made impulses', in schizophrenia; compulsive actions, e.g. handwashing); desire (addictions, sexual disorders); appetite (anorexia, bulimia); motivation (hysteria); belief (delusions); perception (hallucinations); and thought (obsessive thoughts; also thought insertion, withdrawal and broadcasting, in schizophrenia). Mental disorders also include wider disturbances of personal identity (e.g. multiple personality disorder), of relationships based on empathic understanding (autism), and of behaviour (e.g. in personality disorder).

The diversity of psychopathology is important practically—you will remember from Session 1, that psychiatrists do a full 'mental state examination' (or MSE), covering all of these areas; and for each area, we need to be aware of the precise features of all the possible 'symptoms' that may be present. But the diversity of psychopathology is also important philosophically. As a key

feature of the 'Rylean' map, any philosophical analysis of the concept of mental disorder must explain the diversity of its constituent symptoms compared with those of bodily disorder.

Feature 2 of mental disorder: conceptual distance from bodily disorder

Most people recognize that some mental disorders are more, and others less, intuitively like bodily disorders. Psychiatrists, being the most medical of mental health practitioners, have traditionally emphasized the similarities between mental and bodily disorders, while antipsychiatrists, as you might expect, have emphasized the differences between them. Even in this 'debate about mental illness', though, both sides have to start from the fact (a fact of the 'logical geography' of mental disorder) that there are both similarities and differences between them. The trick is to show, in the terms of reference of this debate, whether it is the similarities (for psychiatrists) or the differences (for antipsychiatrists) that are the more important.

We will be returning to the debate about mental illness in detail in the next two sessions (Session 3 for the antipsychiatrists, Session 4 for the psychiatrists). If, though, we combine the fact that there are both similarities and differences between mental and bodily disorders, with Feature 1, the diversity of mental disorders, we see that the starting point for the debate has to be less polarized. Some mental disorders are more and others less like bodily disorders. Hence there is no global 'mental disorder' that either is or is not relevantly similar (psychiatrists) or dissimilar (antipsychiatrists) to 'bodily disorder'.

The need for a less polarized starting point in the psychiatry/antipsychiatry debate is brought out clearly by our map. Thus, the dementias are generally placed nearest to bodily medicine, these disorders indeed being included among what are often called the 'organic' psychoses (though, as emphasized in Chapter 3, the term 'organic' in this context is defined by reference to particular *symptoms*, not to knowledge of underlying bodily causes). Next to the dementias, most people put the functional psychoses (schizophrenia, manic-depressive disorder, and the paranoid psychoses). After this, there is more variability: the disease 'status' of some disorders is highly contentions (e.g. anorexia is 'obviously' a disease for some, 'obviously not' for others); but by and large, depression, anxiety disorders and the addictions, tend to be placed closer to 'disease', with hysteria, reactions to stress (such as post-traumatic stress disorder, or PTSD), personality disorder, and sexual disorders, all further away.

A note on terminology

The diversity of mental disorders (Feature 1), and their variable conceptual distance from bodily disorders (Feature 2), is reflected in the somewhat confused and inconsistent terminology employed in this area. 'Mental disorder' is the most popular generic term for everything on the map, the implication being that all these conditions are in some way different from just plain 'distress'. The term 'mental *illness*' is probably best used for those disorders that are intuitively most like bodily illness (or disease) and, yet, mental rather than bodily. This of course implies everything that is built into the mind–brain problem! (We return to the mind-brain problem later in the book, in Part V.)

This usage is broadly reflected in most mental health legislation. Thus, in the UK's Mental Health Act, 1983, 'mental disorder' is defined as 'mental illness, arrested or incomplete development of mind, psychopathic disorder and or any other disorder or disability of the mind'. We will follow this convention in the rest of this book. Terminological inconsistencies in this area, it should be said, reflect real underlying conceptual difficulties, although, as we will see later, they have certainly contributed to some of the avoidable confusions in the debate about mental illness.

Feature 3 of mental disorder: illness status

This brings us to the third feature of the map of mental disorder, its variable status as illness. This feature of mental disorder, like the last, is differentially spread across the map. These two features, indeed, tend to go hand in hand—the further from bodily disorders a condition is on the map, the more disagreement there is likely to be about its status as a mental illness. Thus personality disorder and hysteria, as conditions the illness status of which is highly contentious, are both conceptually further from bodily illness than the organic psychoses, like dementia.

The two features, however, the conceptual distance of mental disorders from bodily disorders (Feature 2) and their illness status (Feature 3), are not fully co-extensive. This is clear if we look at an important feature of illness, namely that it is an *excuse*. Thus, illness excuses from responsibility. As a feature of illness in general, bodily as well as mental, this has been emphasized especially by sociologists, for example by Talcott Parsons in his early, and now classic, study of deviance (1951): if I am ill, it is not my fault that, say, I fail to turn up for work (hence the need for an 'off work' medical certificate). The status of m*ental* illness as an excuse is important especially in forensic contexts. The intuitive basis of this is that someone who is mentally ill, or at any rate severely mentally ill, is not responsible for their actions. They are 'irrational', as we say. This is also closely related to the ethical justification of involuntary psychiatric treatment. Someone who is irrational, our intuitions suggest, may not be competent to choose for themselves whether or not they should have treatment. (We return to both aspects of the 'excusing' status of mental illness in Part IV.)

It is because illness in general, bodily as well as mental, excuses, that, as noted above, the illness status of mental disorders (Feature 3), runs closely with their conceptual distance from bodily disorders (Feature 2). But as also just noted, the two features are not fully co-extensive. Thus, dementia is intuitively closest to bodily disorders; however, in some administrations, it is excluded from the legal provision for involuntary treatment. The *functional psychoses*, on the other hand, although intuitively further from bodily disorders, are the paradigm cases both of mental illness as an excuse (especially with delusions—see later in this part) and of (justified) involuntary treatment (see Part IV).

It is the centrality of the functional psychoses in this respect that led the radical antipsychiatrists (such as Thomas Szasz and

R.D. Laing—see Session 3), to focus their attacks on such conditions as schizophrenia. If schizophrenia falls (as a genuine illness), they argued, the concept of mental illness falls with it! On the other hand, personality disorder is both intuitively distant from bodily disorders and highly contentious as an excuse in law; addiction is equivocal (for example, Aristotle (1980, p. 60, lines $1113^{b}20$–$1114^{a}6$) argued in the *Nichomachean Ethics* that a crime committed when drunk, far from being excused, deserves a double punishment); and hysteria is often written off as mere malingering.

Feature 4 of mental illness: value-ladenness

This fourth feature of mental disorder also runs broadly parallel with Features 2 and 3. That is to say, the further from bodily disorders a mental disorder is, and the more contentious is its status as a mental illness, the more overtly value-laden is it likely to be.

The value-ladenness of mental disorder is a crucially important feature of its logical geography. It is central to many of the issues in the psychiatry/antipsychiatry debate, for example, as we will see. Before going on, then, it will be worth looking at it in a little more detail, starting with the meaning of the term 'value'.

EXERCISE 4 (5 minutes)

Before going on, write down as many senses of the term 'value' (or 'evaluative') as you can think of. Which of these applies to mental disorders?

The meaning of value

Like many important terms in philosophy, 'value' is used in everyday language with a variety of meanings: to put a monetary value on, to roughly estimate, to evaluate as opposed to exactly measure, to evaluate a (mathematical) equation, and so on. In the context of the debate about mental illness, however, value is used to mean good/bad in contrast to facts (or evaluation in contrast to description). In this good/bad sense of value, we say 'this is a good pencil' (a value judgement evaluating the pencil) in contrast to 'this is a blue pencil' (a statement of fact, describing the pencil).

Like many other important terms in philosophy, there are also whole philosophies on what 'value', even in the good/bad sense of the term, actually means! Think about these for yourself before going on.

EXERCISE 5 (10 minutes)

Write down a few more examples of the good/bad use of value terms and then pair them with value-free, factual examples. Now think about two questions:

1. Are all your examples of value terms of the same general kind, or can good/bad uses of value terms be further subdivided or classified?
2. How easy is it to distinguish fact from value?

The point of this exercise is to start you thinking about value terms in anticipation of some of the work we will be doing in Session 3 and later in this part.

The varieties of values

You may have noticed from your further examples

1. That even good/bad uses of the term 'value' (as opposed to the other uses of the term noted a moment ago) come in varieties—there are moral ('he is a wicked man'), aesthetic ('this is a beautiful rose'), prudential ('he is a foolish man'), etc., varieties of value. This will be important especially when we come to consider specifically medical value (e.g. in relation to involuntary psychiatric treatment). Philosophers have tended to neglect the varieties of value, but see G.H. von Wright's *The Varieties of Goodness* (1963) for a notable exception.
2. That there is no easy distinction between value and fact. Everyday language is a rich tapestry, with fact and value (as well as many other linguistic threads) woven into it. This does not mean that it is impossible to unpick the threads, or that it is always a mistake to do so; however, it does mean we need to proceed carefully.

This last point, in particular, will be important when we start to work on the implications of the more value-laden nature of mental disorders compared with bodily disorders.

No dichotomy—but a distinction

Before moving on, though, it will be worth spending a moment or two on the fact/value (or description/evaluation) distinction itself. It is sometimes suggested, more in philosophical than non-philosophical circles, that the distinction between fact and value, along with other widely debated distinctions (analytic/synthetic, see Chapter 5; mind/brain, see Part V; and so on), is otiose, that no self-respecting philosopher would nowadays talk in these terms at all.

The American philosopher, Hilary Putnam, for example, actually called his recent collection of essays *The Collapse of the Fact/Value Dichotomy* (2002). But what did Putnam actually mean by this?

EXERCISE 6 (15 minutes)

Read the short section from page 9 of:

Putnam, H. (2002). The Empiricist background. Chapter 1 in *The Collapse of the Fact/Value Dichotomy and other Essays.* Cambridge, MA: Harvard University Press.

Link with Reading 2.1

- What do you take Putnam to mean by the distinction he draws between distinctions and dichotomies (or dualisms)?

Putnam's point, which he attributes to the American pragmatist John Dewey, is that a distinction is not a dichotomy (or dualism). A dichotomy applies across the board, all cases (of the relevant kind) falling on one side or the other (fact *or* value, analytic *or* synthetic, mind *or* brain). A distinction is considerably more modest. A distinction may be helpfully drawn, Putnam says, 'for certain purposes' without implying a dualism, i.e. that it can be drawn in all cases of the relevant kind.

Thus, to take a non-medical example, 'above' and 'below' is a distinction that may be helpfully drawn for some purposes, but that clearly cannot be drawn in all cases (because there will be cases of equality). Similarly, then, we will be arguing in this part that for certain purposes in health care it may helpful to distinguish fact from value (or description from evaluation). We will be suggesting, in particular, that there are concepts (such as the concept of disease) that, although widely taken to fall firmly on the fact side of the distinction, are none the less (in part) evaluative in meaning. Recognizing this evaluative element in the meaning of such concepts, we will further suggest, is helpful (in Putnam's terms) not only for theory but also for practice. It is helpful for theory in that it allows us to explain certain otherwise inexplicable features of the way these terms are actually used (the features of their 'ordinary usage', as we will call it in Chapter 4). It is helpful for practice in that it leads to an enriched model of healthcare decision-making in which description and evaluation have equal and complementary roles (values-based practice, see Part IV, especially Chapters 18 and 21). But all this is very far from claiming, and certainly does not require, that the distinction can be driven all the way back, that it can be established, to use Putnam's term again, as a dichotomy. To the contrary, as one of us has argued elsewhere (Fulford, 1989, chapter 10), psychopathology itself (specifically, the remarkable logical range of delusions, see chapter 3), gives a uniquely clear signal that the fact/value *distinction* does *not* go all the way back, that it is not, in Putnam's terms, a *dichotomy*.

Returning, then, to our map of mental disorder, it is in the good/bad sense of value, and recognizing what Putnam goes on to call the entanglement of fact and value in ordinary usage, that the parts of the map of mental disorder farthest from bodily disorders are the more value laden. We can see this in a number of ways:

1. *Medicine merges with morals*: many of the conditions at the edge of the map of mental disorder are close to moral conditions in differential diagnosis (e.g. psychopathic personality disorder is close to delinquency; alcoholism to drunkenness, hysteria to malingering).
2. *Excuses merge with no excuse*: this means that peripheral conditions are more likely to be understood in terms of moral responsibility, both in situations involving involuntary treatment and in respect of mental illness as an excuse in law (in both types of case, as we have seen, it is usually psychotic conditions, shown here at the centre of the map, that are considered paradigmatic).
3. *Mental disorders are defined (in part) by moral criteria*: even in 'scientific' classifications, the criteria by which some conditions near the edge of the map are (partly) defined, are social-evaluative rather than scientific-factual. For example, in the American classification, The Diagnostic and Statistical Manual, 'Conduct Disorder' is defined as 'a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate *societal norms or rules are violated*' (APA, 1994, p. 290, emphasis added), and the paraphilias (disorders of sexual object choice) are defined in terms of behaviour that brings the individual '*into conflict* with sexual partners or society' (ibid., p. 280, emphasis added). We look at these again in Part III. (We return to classification in detail in Part III and IV.)

The four features and the philosophical problem of mental disorder

In all, then, there are four features of mental disorder for which any philosophical analysis of the concept must account: (1) diversity; (2) distance from bodily disorder; (3) variable status as illness; and (4) degree of value-ladenness.

In the next two sessions, we will examine two broad approaches to explaining these features of mental disorder: the non-medical (usually antipsychiatric approach), and the medical (usually pro-psychiatric approach), respectively. We will find that neither approach is able to explain the features of the map *as a whole*. This will bring us, by the end of this chapter, to a deeper understanding of the 'problem of mental illness' as a philosophical problem, and of the nature of philosophical problems in general.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. As with Session 1, the last exercise in this session involves reflecting on the material we have covered and drawing out your own key 'take away' points. As we said at this point in Session 1, it is important to think about and write down your own points before turning to the one's we selected (listed at the end of the book). The points that are significant from your particular perspective may be unique to you!

However, among the points to consider are:

1. Whose metaphor did we use to describe the conceptual map of mental disorders in Figure 2.1? What is its significance for philosophical theory?
2. What are the main areas (the main groups of conditions) in the conceptual map of mental disorder?

3. List the four conceptually significant features of the map that we identified (you may have thought of others)
4. In Putnam's view, is there a fact/value distinction or a fact/value dichotomy?
5. There are three ways in which mental disorders are in general more value-laden than bodily disorders. What are they?

Session 3 Antipsychiatry and the debate about mental illness

Since the 1960s there has been a wide-ranging and at times polemical debate about the validity of the concept of mental illness. In this session we look at a selection of the many different views falling broadly under the flag of 'antipsychiatry'. In Session 4 we will consider the opposing 'pro-psychiatry' view. What will emerge, though, from the two sessions taken together, is not so much the differences (important as these are) as the extent of the *similarities* between the arguments of many on both sides in this debate.

These similarities have not been well recognized (Fulford, 1989, chapter 1). Yet they are the key to a deeper understanding of the nature of the 'problem of mental illness'; and hence of this problem as illustrating the nature of philosophical problems in general.

Thomas Szasz, philosophy, and antipsychiatry

Although Thomas Szasz has always resisted the description 'antipsychiatrist', he was one of the first to attack psychiatry primarily on the *conceptual* grounds that mental disorders are not, properly, medical disorders. In attacking the very *concept* of mental illness, Szasz was the most explicitly philosophical of the early antipsychiatrists (in the sense of the term 'philosophy' as used in this book; although Szasz himself never claims to 'be' a philosopher). We will thus start with a careful look at Szasz' arguments against the concept of mental illness before considering the wider antipsychiatry movement.

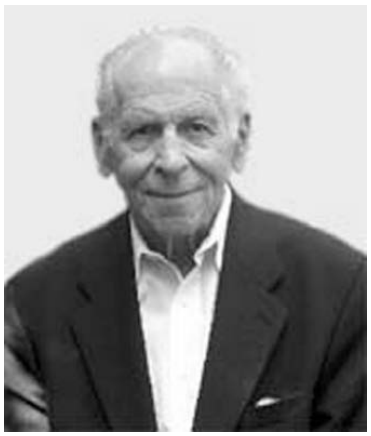

Fig. 2.2 Thomas Szasz

EXERCISE 7 (60 minutes)

Read the opening section, page 113–114, from:

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

Link with Reading 2.2

Spend some time on this, thinking about Szasz's argument, as it runs from problem, to method, to conclusion.

- What, exactly, are his objections to people being said to be mentally ill?
- What dangers does he see in this?
- How does he seek to show that the very concept of mental illness is invalid?
- What is his conclusion about the real nature of these questions?

Thomas Szasz is an American psychiatrist. He began publishing in an uncompromisingly antipsychiatric vein in the late 1950s soon after being made Professor of Psychiatry at Syracuse University in upstate New York. Not surprisingly, he ran into a lot of flack! However, he hung on to his job while at the same time never shifting his basic position. He is now a distinguished Emeritus Professor at Syracuse who continues to publish widely on antipsychiatry themes and to lecture in many parts of the world.

Szasz's objections to the concept of mental illness

Like many other antipsychiatrists, the core of Szasz's objection to the concept of mental illness is that it dehumanizes people. Everyone, Szasz argues, has 'problems of living'. However, we should not see these as illnesses. Why not? Because, essentially, to say that someone is ill is to stop them taking responsibility for dealing with their own problems. (Remember from Session 2, that illness status tends to go with loss of responsibility.)

EXERCISE 8 (5 minutes)

Think about this for a moment in relation to the map of psychiatry that we looked at in the last session. Where is Szasz locating mental illness?

Remember that as we moved to the left of the map, so the links between mental illness and moral problems became more transparent. In effect, then, Szasz shifts mental illness as a whole

right off the edge of the map of mental disorder and into the area of moral (or, more broadly, human) problems.

Mental illness is different from bodily illness

This shift to the left, as we might call it, becomes clearer still if we look at Szasz's method, at how he seeks to undermine the concept of mental illness, to show that mental illness is a myth, that it is not a genuine illness in the sense that bodily illness is genuinely illness. In this, Szasz is in effect pointing to what we could call the right-hand side of our map, taking bodily illness to be the paradigm for all illness. Bodily illness, he says (p. 114), is a deviation from clearly defined factual norms of the 'structural and functional integrity of the human body'. It is a matter of anatomy and physiology. Hence, he suggests, while individual diseases may be defined in different ways, they all involve deviations from these *factual* norms. It is by reference to factual norms, then, that genuine illnesses are defined.

But what about mental illnesses (so-called)—hysteria, depression, schizophrenia even? When we say of someone with depression that they are ill, are we referring, either directly or indirectly, to factual norms of bodily structure and functioning? Surely not. Conditions of these kinds certainly involve deviations from the norm. But the norms concerned, Szasz argues, are 'psychosocial, ethical, and legal' in nature (p. 114). Mental illness, so-called, is thus a concept of a radically different kind from bodily illness, mental illness are, certainly, problems. But they are not *medical* problems. They are, rather, 'problems of living' (e.g. p. 113 and again p. 118).

Szasz' core argument

Szasz's core argument, then, is that all those conditions widely regarded as mental illnesses are, really, defined by moral (or more broadly *evaluative*), rather than by factual (and by implication, *medical*) criteria. In the terms of our map, then, mental disorders are not, merely, closer than bodily illnesses to moral categories. Mental disorders really *are* moral categories. The concept of *mental* illness is thus an illegitimate extension of the concept of bodily illness. Mental illness is a myth.

EXERCISE 9 (20 minutes)

Before going on, spend a few minutes thinking about Szasz's argument. Review his strategy. Revise, if necessary, your original outline of his argument (from problem, to method, to conclusion), and note down briefly its strengths and/or weaknesses from your point of view.

We can summarize the structure of Szasz's argument thus:

1. The *problem*, as understood by Szasz, is the meaning of mental illness: being obscure in meaning, it is problematic in use, merging, in particular, with moral categories (our Feature 4 of the map): the meaning of bodily illness, by contrast, Szasz assumes, as relatively transparent and, correspondingly, the concept is relatively unproblematic in use.
2. Szasz' *method* is to proceed by comparing (the problematic) mental illness with (the unproblematic) bodily illness. He takes examples of bodily illness to be paradigmatic of genuine illness; such examples suggest that genuine illness is defined by (or means) deviation from clear-cut scientific-factual norms of bodily structure and functioning; however, conditions widely regarded as mental illnesses are defined by social-evaluative norms. Hence:
3. Szasz's *conclusion* thus has to be that mental illness, being so radically different in meaning from the paradigmatic bodily illness, is a myth.

Consequences of Szasz's argument

We will look at some of the objections to Szasz's arguments in a moment. It is important to recognize, though, just how fertile his position has been. In his own prolific output, he has explored the consequences of the 'myth of mental illness' in many areas: for particular 'disorders' (e.g. hysteria, schizophrenia, addiction); for its medicolegal implications; for the historical and cultural origins and ramifications of the concept; and so on (see Reading Guide).

A clear and forceful writer, Szasz mounted a strong and direct challenge to the medical model of mental disorder, i.e. to the idea that mental disorders are essentially no different from heart disease, diabetes or GPI (general paralysis of the insane, the tertiary, and before pencillin, final, phase of syphilis).

Szasz and the nature of philosophical problems

Work as fertile as this, whatever the denials of its opponents, is unlikely to be trivial. It may be wrong but it is certainly no mere 'playing with words'. Szasz's work thus illustrates an important general characteristic of philosophical problems. Whether pursued by card-carrying philosophers or not (as noted, Szasz never claims to be a philosopher), the problems of philosophy go to the very basis of our conception of ourselves and of our world.

Problems of this kind are difficult. They are literally at the edge of our powers of penetration, and much philosophical work is thus at best obscure, at worst unproductive. Unlike much scientific research, therefore, philosophy is a high-risk venture, more likely than not to be inconclusive. But when it *does* pay off, it pays off in a big way. (A recurring delusion of philosophers is that they have reached, and can prove that they have reached, the limits of the penetrable. This is one way to understand an element of discontinuity between the earlier and the later Wittgenstein. While in his *Tractatus Logico Philosophicus* (1921) the younger Wittgenstein set out to analyse *the logical form* of the proposition, in his later work he poked fun at the idea that one might have 'absolutely the right concepts'. Indeed he invented hypothetical cases of tribes with different concepts to cast doubt on this.)

We will return to the importance of Szasz's work in Chapter 6 when we look in more detail at the products or outcomes of philosophical work. But we can see already that one important 'pay off' from the ideas he was exploring in the early 1960s, has

been what would now be called 'empowerment', an assertion of the *agency* of the patient. His work thus anticipated the whole patient power movement. This has been important practically—patient-centredness in health care, respect for the views of the users of services, and the incorporation of users of services into all stages of the planning and implementation of health care—are nowadays taken for granted in many parts of the world (though sometimes more in word than deed!).

It is important to add that empowerment is especially significant in *mental* health. Psychiatric patients are among those disadvantaged groups who remain notoriously vulnerable to abuse. There are many reasons for this (see later in this chapter and in Part IV). However, the loss of agency implied by taking someone to be ill is a crucially important factor and one that is highlighted by Szasz's work.

Back to the debate about mental illness

The central importance of Szasz's work has been to counter the idea that mental illness is just like bodily illness. In particular, he forced us to take seriously the links between mental illness and moral categories. Szasz also helped to give the whole antipsychiatry movement a high profile by taking a very strong and uncompromising line. It is, however, this strong line that renders his position open to criticism. We return to the counter-arguments of the pro-psychiatrists in Session 4. As to Szasz' position, there are many points, both practical and theoretical, that could be made against him. Here are a few examples (see also Reading Guide).

Practical points

Szasz's extreme position would exclude many from the help they really need. The British social psychiatrist, John Wing, described as 'repellant' (1978, p. 244) those who (like Szasz) would deny treatment to someone with suicidal depression (remember Mr AB in Session 1 of this chapter). Many among the user movement in psychiatry endorse the value even of physical treatments such as drugs, while at the same time insisting on the importance of involving patients themselves in decisions about how and when they are used—Peter Campbell, a writer on user issues in the UK gives a clear and balanced statement of this in his account of his own manic-depressive illness (Campbell, 1996). See also the now classic survey by Rogers *et al.* (1993).

Theoretical points

Szasz's extreme position is vulnerable theoretically in several respects, in particular:

- His characterization of mental illness as defined by social-evaluative norms, seems to exclude all the factual information, including knowledge of brain structure and functioning, currently available and likely to be discovered in the future. Szasz is of course well aware of this. His position is that if a brain basis for schizophrenia is discovered he will regard the condition as being on a par with GPI, i.e. it will then be a *bodily* illness. (For objections to this, see Session 4.)
- His characterization of bodily illness excludes conditions (such as migraine) the bodily causes of which are not known; and it includes conditions (such as extreme physical fitness) that are not illnesses.
- His approach has been attacked as dualistic, driving a false wedge between mind and body, a wedge that psychiatry, in particular, is working to remove.

Szasz and the map of mental disorders

We noted a moment ago that in terms of our map of mental disorders, Szasz's extreme view amounts to locating all mental disorders, however illness-like, off to the left, as moral problems. Another way of putting this is to say that his extreme view emphasizes the differences between mental and bodily illness (in particular the relatively value-laden nature of mental illnesses) at the expense of the similarities.

This is not illegitimate in itself. But as noted earlier, for a satisfactory *philosophical* theory, some account must be given of the features of the map *as a whole*. Hence in order to legitimate his emphasis on the differences between mental disorder and bodily disorder, Szasz must offer some account of why, in other respects, the two kinds of disorder at least *appear* similar. For philosophical purposes, for purposes of getting clearer about the *meaning* of mental disorder, it is not enough merely to draw out and rely on the differences between it and bodily disorder.

So Szasz's antipsychiatry can be characterized as focusing on one part of the map (the value-ladenness of mental disorder) instead of seeking to explain its features as a whole. This is not sufficient philosophically. It *is* important, though. In focusing on this aspect of the map, Szasz has drawn out and emphasized something (variable degrees of value-ladenness) that, as we will see later, is important not only for psychiatry but also, more generally, for medicine as a whole. We will return to the lessons from the debate about mental illness for medicine as a whole at several points in this book.

Antipsychiatries and the map of mental disorders

We have considered Szasz's antipsychiatry in detail as one of the most distinctively *philosophical* attacks on the concept of mental illness, i.e. an attack that goes to the heart of the *meaning* of the concept. Szasz in effect argues that 'mental illness' is an oxymoron—something *cannot* be both an illness and mental, *logically* cannot, because illness *means* 'bodily illness'. The very concept of '*mental* illness', then, is self-contradictory, according to Szasz, in the same way that 'male bitch' is self-contradictory (i.e. because 'bitch' *means* 'female dog').

Other forms of antipsychiatry, and they are many and diverse, are less philosophical, in the sense that they are less concerned explicitly with meanings. Like Szasz's antipsychiatry, though, they can be understood as focusing on parts of the map at the expense of its features as a whole; however, also like Szasz's antipsychiatry, in focusing in this way they have all contributed important new understanding of the diverse forms of mental disorder.

Five forms of antipsychiatry

Some of the main models advanced by antipsychiatrists, mainly in the 1960s and 1070s, can be summarized thus:

1. *The psychological model.* The British psychologist, Hans Eysenck, focusing (in effect) on the behavioural zone of the map, was among those who argued that mental disorders are learned abnormalities of behaviour. The disease model is inappropriate, he claimed, both as a model for investigating aetiology, and as a basis for treatment (e.g. Eysenck, 1968).
2. *The labelling model.* This model has been advanced particularly by sociologists, such as the American Thomas Scheff (1974). It emphasizes the extent to which the features of mental disorder, so called, are, really, no more than a response of the individual to being labelled as deviant. Although not sufficient to explain the onset of mental disorder, labelling processes have been shown to be powerful maintaining factors that may actively inhibit recovery (see, e.g. in the Reading Guide, Rosenhan's (1973) classic study; and recent literature on 'recovery' (Allott *et al.*, 2002)).
3. *Hidden meaning models.* Relevant especially to the psychosis zone of the map, this covers all those versions of antipsychiatry that emphasize the hidden meaningfulness of apparently meaningless (or irrational) behaviour. Thus the Scottish psychiatrist, the late R.D. Laing, in his first book *The Divided Self* ([1960], 1965, with a new preface), gave a detailed analysis of how the apparently meaningless symptoms of someone with schizophrenia could be decoded, once their origins in the patient's contradictory experiences of others were recognized.
4. *Unconscious mind models.* A key feature of the whole psychoanalytic movement is the claim that conscious mental life is a product of unconscious mental activity. Recognizing this, much that is apparently irrational can be made comprehensible in terms of unconscious counterparts of motives, reasons, desires, fantasies, and so forth. The Viennese founder of psychoanalysis was Sigmund Freud (see Part III). His theory was originally inspired by, and remains important especially in relation to, non-psychotic disorders.
5. *Political control models.* The essence of this version of antipsychiatry is that the medical model of insanity is a social or political construction devised (consciously or unconsciously) for the purpose of legitimizing the control of what society deems deviant, dangerous, or otherwise unacceptable. Thus the French philosopher–historian Michel Foucault argued that the medical model was 'invented', or at any rate came to dominance, in the nineteenth century in response to the needs of the industrial revolution, and led to the rise in all industrialized countries of the large asylums (Foucault, 1965). In modern times, as we will see in Part IV, political dissidence has been the basis of attributions of madness in totalitarian regimes; and the boundary between 'madness and morals', or between health care and policing, remains contentious in relation to 'dangerous' conditions such as psychopathy and some sexual disorders.

Highlighting parts of the map

These models are of course not as sharply distinct as this list suggests: labelling, for example, is an important aspect of the learning processes emphasized by psychologists; these in turn play a large part in the effects of the institutionalization of madness resulting from the asylum movement; and practically important ways of understanding these effects have come from the psychoanalytic movement.

None the less, even if not fully distinct, the models do offer well-defined approaches to mental disorder, each of which has proved important to parts of the map. Indeed, their importance, like the importance of Szasz's model, is in part in the extent to which they have become incorporated, alongside the medical model, into current theory and practice. For example,

- psychological treatment methods are now often the treatment of choice for many common non-psychotic disorders (depression and anxiety, for example);
- the power of labelling in reinforcing the features especially of long-term mental illness has been emphasized especially in social psychiatry (see e.g. Wing, 1978).

Schizophrenia may not be, as Laing argued, a sane response to an insane society, but a particular kind of family environment can increase the risk of relapse (Brown *et al.*, 1972; Leff and Vaughn, 1985).

Psychoanalytic and psychotherapeutic ideas, although still far from universally accepted in medicine, have become so well integrated with everyday practice as to be hardly recognizable for what they are. The British psychoanalyst and writer Anthony Storr, in a scholarly reappraisal of Freud's work, brings this out clearly (see Storr, 1989).

Political control models, as noted above, have proved all too tragically prescient with the widespread abuses of psychiatry, most notoriously in the former USSR (Bloch and Reddaway, 1977), but also in many other parts of the world (Chodoff, 1999). We return to the direct links between the latter and Szasz's argument about the concept of mental illness in Part IV.

Empirical evidence that at least some of these models are now present in everyday practice has been produced by the British social scientist, Anthony Colombo, in his work on implicit models of disorder in forensic psychiatry (Colombo, 1997) and in community care (Colombo *et al.*, 2003a). Colombo's work provides a paradigm for combining philosophical and empirical research methods in mental health (Fulford and Colombo, 2004) to good practical effect—see Williams (2004) on training; Heginbotham (2004) on policy, and Williamson (2004) on service delivery.

Antipsychiatry and psychiatry today

The absorption of antipsychiatric themes into mental health practice has led some, especially in psychiatry, to believe that

antipsychiatry is dead. That it is not, that antipsychiatry is alive and well, is evident:

- in the continued growth in importance of 'patient power' movements;
- in the organization of mental health services increasingly along multidisciplinary lines;
- in diatribes against psychiatrists from the courts—for example, in the notorious 'Yorkshire Ripper' case (of a man in the UK who murdered several prostitutes in the north of England), the Judge rejected the evidence of both prosecution and defence psychiatrists that the defendant was suffering from schizophrenia;
- in 'scandals' about failures of psychiatric care;
- in the newspapers; and
- in the popularity and continued selling power of antipsychiatry literature.

From the psychiatric side, on the other hand, a strongly biological version of the traditional medical model remains dominant. There is much talk of 'whole person' medicine (see, eg., Cox *et al.*, forthcoming); and of the need for a 'biopsychosocial' model (for an excellent statement of the need for this, see McHugh and Slaveney, 1983, who are two founder members of the American group, the Association for the Advancement of Philosophy and Psychiatry); but the continuing dominance of the medical model is evident, none the less, in the overwhelming priority given to the biological and clinical sciences in research funding, in the syllabus for higher training in psychiatry, and in the papers accepted for academic meetings. The dominance of 'medical' aspects of mental disorder in the implicit models of psychiatrists, as compared with those of social workers and psychiatric nurses for example, has also been demonstrated empirically in Colombo's work (noted above).

In Session 4, we will examine the biological medical model and its role in psychiatry. We will find that like the models of the antipsychiatry movement, the medical model has important strengths. None the less, it also turns out to be a partial view, focusing on one feature of the map of mental disorders at the expense of the rest.

Reflection on the session and self-test questions

As with previous sessions, we are now ready to reflect on the materials in this session. Run over the session briefly and write down the key points that you find significant. Then write brief notes about the following:

1. What was Szasz' essential strategy? On what, precisely, did he focus his arguments?
2. Why exactly did he argue against the medical model in psychiatry? What was he concerned about?
3. What were the three structural elements or stages in his core argument that we identified?
4. What are the strengths of his argument (name two) and its weaknesses (name two)?
5. Name at least three other 'models' of mental disorder reflected in 'antipsychiatric' literature.
6. How, broadly speaking, are different models related to the 'map' of mental disorder introduced in Session 2?
7. Do *you* think antipsychiatry is alive or dead today?

Session 4 The medical model (and beyond)

Until the 1960s, when the debate about mental illness was getting under way, there was little in the way of concern about conceptual problems in medicine. The good and sufficient reason for this was that the problems facing medicine had, to this point, been very largely empirical in nature. The challenge was to understand and find cures for the major diseases—overwhelming infections, cancer, nutritional disorders. That such conditions were indeed *diseases* was not in question; and what was *meant* by calling these conditions diseases seemed all too self-evident.

At about this time, though, concerns began to be raised about the meaning of 'disease' even in physical medicine. These concerns were driven to a large extent by the very success of scientific research. A combination of advances in diagnostic methods and more powerful treatments raised new questions about the distinction between health and disease. Such questions had been the subject of philosophical debate since antiquity. But they became now, for the first time, matters of real *clinical* concern.

R.E. Kendell, philosophy, and pro-psychiatry

Important early work in this area was done by the British chest physician, J.G. Scadding. It is essentially his analysis of the concept of 'disease' (set out fully, for example, in Campbell *et al.*, 1979), which was picked up by British psychiatrists responding to Thomas Szasz and others in the early years of the debate about mental illness. This was notably the case with a newly appointed (at the time) Professor of Psychiatry at Edinburgh University, R.E. Kendell.

EXERCISE 10 (60 minutes)

Read the six extracts from:

Kendell, R.E. (1975). The concept of disease. *British Journal of Psychiatry*, 127: 305–315.

Link with Reading 2.3

Think about Kendell's line of argument comparing it with Szasz' in the last session. Think about the similarities as well as

the differences between them in: (1) their characterizations of the problem; (2) their working methods; and (3) their conclusions. In particular, consider why both authors think it important to examine what is meant by bodily illness. And what do they decide 'bodily illness' means?

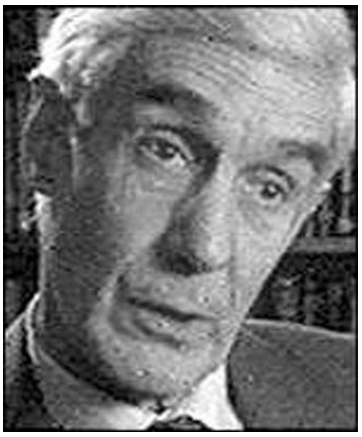

Fig. 2.3 R.E. Kendell

Like Szasz, Kendell was a professor of psychiatry. Also like Szasz, he was concerned directly with the problem of mental illness as a *conceptual* problem. Indeed this paper, which he gave first as his inaugural lecture at Edinburgh, was conceived as a direct response to the challenge of antipsychiatry.

Kendell was very much an establishment figure. After his time as Professor of Psychiatry at Edinburgh University, he became Chief Medical Officer for Scotland. He was then elected President of the Royal College of Psychiatrists in the UK. He was widely read in the philosophy of science and the humanities generally, as well as in medicine. He was one of several psychiatrists working in the UK in the 1970s and 80s, who tackled the conceptual problems of mental health head-on (as well as doing important empirical research). Later in his career, he became a strong supporter of the new philosophy of psychiatry: he gave one of the opening addresses at the millennial international conference in Florence, for example. We return to Kendell's work on psychiatric classification and diagnosis in Part III.

Kendell and Szasz: the same or different?

In this seminal paper, Kendell takes a pro-psychiatry stand which is as uncompromising as Szasz's antipsychiatry stand.

The differences between Kendell and Szasz are clear enough. The most notable difference is of course their contrary conclusions. Szasz had concluded that mental illness is a myth. Kendell concludes that at least some of the conditions widely regarded as mental illnesses are essentially similar to bodily illnesses; hence, mental illness is very far from being a myth. In the terms of our conceptual map of mental illness, then, where Szasz locates mental illnesses right off the map to the left (*as* moral problems), Kendell locates them right off the map to the right, *as* bodily illnesses.

In addition to the differences, though, there are also important *similarities* between Szasz and Kendell. These are more subtle, but also more remarkable. For what they amount to is that Szasz and Kendell, although coming to diametrically opposite conclusions, adopt essentially the same form of argument. Thus, Kendell shares with Szasz *two assumptions about the problem* with which they are concerned, and the same working method, i.e. a common *form of argument*. Thus:

- *Shared assumption 1*: *mental illness is the problem*. Kendell and Szasz both assume that it is the concept of mental illness that is 'the problem'. Thus, Kendell (p. 305), notes that the many and varied critics of psychiatry have 'one central argument in common—that what psychiatrists regard as mental illness are not illnesses at all', and he continues 'The purpose of this essay is to examine this proposition'. For Szasz, the assumption that mental illness is the problem, is evident in the very title of his (1960) paper, 'The *Myth* of mental Illness' (emphasis added).

  In precisely what sense or senses mental illness is 'the problem' is less clear. Again, however, we can identify at least two shared subassumptions here, (1) that 'mental illness' is more obscure in meaning than 'bodily illness', and (2) that an important respect in which it is more obscure in meaning is that is it more value-laden. Szasz makes this explicit: he argues, as we noted in the last session, that if we look carefully at the concept of mental illness, we see that it is defined by norms that are 'psycho social, ethical and legal' (Szasz, 1960, p. 114). That mental illness is more value-laden is at least implicit in Kendell's paper, for example in his concluding comments (in which he is remarkably close to Szasz) about the unwarranted expansion of psychiatry's concerns from dealing with 'madness' to the 'absurd claims (that) all unhappiness and all undesirable behaviour are manifestations of mental illness' (p. 314).

- *Shared assumption 2: bodily illness is not a problem*, relatively speaking. Just as both authors take mental illness to be the problem, conceptually speaking, so both take the concept of bodily illness to be at least relatively unproblematic. As with Assumption 1, there are two subassumptions, (1) that bodily illness is relatively transparent in meaning, and (2) that it is relatively transparent because it is defined, straightforwardly, by reference to factual/scientific norms.

  This second assumption corresponds with the fact that both authors take examples of bodily illness to be paradigmatic of genuine illness. Both indeed consider some of the same

examples (e.g. GPI, or General Paralysis of the Insane, a form of syphilitic brain disease). The underlying message is 'we don't disagree about whether a given condition *is* a bodily illness, hence we must know what we *mean* by bodily illness'.

Kendell does more work on the meaning of bodily illness than Szasz. He reviews the historical development of the concept of disease. Both conclude, however, that whatever the full sense of the term, its core meaning is evident enough. Both, moreover, agree in taking bodily illness to be defined in objective, value-free, scientific terms.

- *Common form of argument*: *to determine the validity of mental illness by comparing it with bodily illness*. Given that Kendell and Szasz both take the meaning of (the paradigmatic) bodily illness to be (relatively) transparent, it is natural that they should both proceed by directly comparing mental illness with bodily illness. This form of argument takes bodily illness to be the template, the true coin against which the less certain coin of mental illness is to be measured.

The key point of disagreement

Most people reading Kendell's (1975) and Szasz's (1960) papers for the first time fail to notice these similarities. This is perhaps because, in a sense, they are just *too* obvious. What stands out is the *differences* between them, their embattled positions at opposite poles of the mental illness debate. We will return in Chapter 4 to the importance for philosophical method of such failures to spot the obvious. For the moment, however, we need to think further about the significance of the *similarities* between Szasz and Kendell as now identified. Where do they take us? Do they matter? In particular, what do they tell us about the debate about mental illness?

EXERCISE 11 (10 minutes)

Take a moment to think about the significance of the points of similarity between Szasz and Kendell. Despite being representatives of opposite poles in the debate about mental illness, they share similar assumptions about: (1) the problem (that the problem is 'mental illness', in particular where it stands between medicine and morals), and (2) the paradigm (that bodily illness is relatively unproblematic and hence the template against which any putative mental illness is to be measured); moreover, (3) both authors adopt the same working method (both compare putative mental illnesses against what they take to be the template of bodily illness).

So, Kendell and Szasz share similar assumptions and a similar method, but they reach opposite conclusions. How come? What is it that they are really disagreeing about? Think about this for yourself and write down your own answer before going on.

The short answer to Exercise 11 is that Kendell and Szasz come to opposite conclusions about mental illness because they disagree, not, primarily, about the meaning of mental illness, but about the meaning of *bodily illness*.

Thus, Szasz takes bodily illness to be defined by anatomical and physiological norms: whereas, he says, mental illness is defined by norms that are ethical, social, and legal; hence mental illness fails to fit the template of bodily illness; hence, Szasz concludes, mental illness is a myth. Kendell takes bodily illness to be defined rather by reduced life and/or reproductive expectations (these being evolutionarily defined norms of 'biological disadvantage'—we return to biological disadvantage later in this part): he then shows that at least some putative mental illnesses are associated with reduced life and/or reproductive expectations; hence *these* mental illnesses, at least, fit the template of bodily illness; hence, Kendell concludes, mental illness is a reality.

EXERCISE 12 (10 minutes)

Obvious? Again, think about this for a moment. Does it suggest that something odd is going on here? In particular, if this is why, despite similar assumptions and a common form of argument, Kendell and Szasz come to opposite conclusions, does it suggest that their original assumptions may need to be revised?

To repeat: the key point that comes out of comparing and contrasting Kendell's and Szasz's arguments, that what they are *really* disagreeing about is not the meaning of mental illness but the meaning of *bodily illness*, This is the key point because, as we will now see, it is the key to a radical redefinition of the terms of the whole debate.

The debate was about bodily illness not mental illness

Up to this point, the debate has been about mental illness. Mental illness, as we saw, was *the* problem no less for Kendell (the psychiatrist) than for Szasz (the antipsychiatrist). And mental illness has been *the* problem also for the large number of other contributors to the debate.

Now, however, we have found that Szasz and Kendell disagree about mental illness essentially *because they disagree about bodily illness*. The terms of the debate itself thus stand to be radically revised. For the debate has turned out to be a debate, not (primarily) about mental illness at all, but about bodily illness. And this means that both the (implicit) assumptions from which Szasz and Kendell proceeded, and also their working method, have now to be completely revised. We can summarize the revisions thus:

1. the problem is now the meaning of bodily illness (not that of mental illness);
2. 'bodily illness', as well as 'mental illness', is thus very far from being transparent in meaning; and hence
3. the method of direct comparison is not appropriate.

Where do we go from here?

Just *how* we should proceed is the subject of the whole of Chapter 4, on philosophical method. But to anticipate a little, notice that there is a sense in which 'mental illness' could still be said to be genuinely more problematic than 'bodily illness'.

Thus, the meaning of 'bodily illness' has turned out to be at the heart of the debate about mental illness (at least as exemplified by Szasz and Kendell; though the same can be shown to be true of the debate generally, see Fulford, 1989, chapter 1). But the debate *appeared* to be about 'mental illness'. Why? Because the concept of mental illness is more *problematic in use*, i.e. clinically, than that of bodily illness. The concept of bodily illness is of course not *wholly* unproblematic clinically—witness the work of Scadding and others noted above (also, in primary care, that of Helman, 1981). But 'bodily illness' is at least *relatively* unproblematic clinically compared with 'mental illness', notwithstanding the fact that it turns out to be equally difficult to define.

The distinction implied here, between *definition* and the actual *use* of a concept in practice, is the key to a working method in philosophy to which we will turn in Chapter 4. As we will find, this method allows us to build on the foundational work of Szasz and Kendell in the debate about mental illness—or, as we should now say, having so radically revised the terms of that debate, the debate about *bodily* illness!

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. What is the historical link between Kendell's arguments and those of Szasz?
2. From whose work and in what area of medicine (bodily or psychological) did Kendell derive his arguments?
3. How does Kendell's definition of bodily illness (or disease) differ from Szasz's?
4. Identify three similarities between Kendell's and Szasz's arguments.
5. What conclusions can we draw from the similarities and differences between Kendell's and Szasz's arguments for the debate about mental illness?

Conclusions

This chapter has been concerned with the nature of philosophical problems, both in general and as exemplified by our particular subject area, mental health.

In *Session 1*, starting from a practical example (the story of Mr AB), we found that in so far as philosophy and science are distinct, philosophy is concerned with conceptual problems, science with empirical.

In *Session 2*, we came back to a central issue for philosophy and mental health, the meaning of the concept of mental disorder. From a conceptual 'map' of mental disorder we drew out four key features that any philosophical account of the concept must explain: (1) the diversity of the different forms of mental disorder; (2) their different conceptual distance from bodily illness; (3) their differential status as species of illness (evident especially in their status as excusing conditions); and (4) the extent to which, being to a greater or lesser extent close to moral categories, they were more or less value-laden.

It is this fourth feature, the value-ladenness of mental illness, which has driven much of the debate about the concept, as set out in *Sessions 3 and 4*. Taking these together, we found that competing models of mental disorder can be understood as having focused on different parts of the conceptual map while failing to explain its features as a whole. Szasz and Kendell, in particular, representing opposite poles in the debate, focused respectively on the extreme left-hand (moral) and extreme right-hand (medical) boundaries of the map. Szasz took mental illness, because more value-laden than bodily illness, to be a moral concept. Kendell, on the other hand, argued that the value-ladenness of mental illness could be translated into value-free factual norms, and hence that mental illness is essentially no different from bodily illness.

In Chapter 4, we will return to the debate about mental illness. We will find that both sides are, in one sense right, in another wrong; and that this is the clue to a way of understanding the concept of mental disorder which is consistent with, and to this extent explains, all four features of the conceptual map of mental disorder, the Rylean logical geography of the concept, which we have explored in this chapter.

First, though, we need to prepare the ground for this more detailed treatment of the 'problem' of mental disorder by taking a more in-depth look at the features of the wide variety of mental disorders with which we are concerned in mental health.

Reading guide

Introductions to philosophy

A well-balanced introduction is Nigel Warburton's (2004) *Philosophy: the Basics*. Each chapter considers a key area of philosophy, explaining and exploring the basic ideas and themes. Simon Blackburn's (2001) *Think: a Compelling Introduction to Philosophy* is a short introduction with a definite story to tell. More advanced are: Baggini and Fosl's (2003) *The Philosopher's Toolkit*, and Guttenplan *et al.*'s (2003) *Reading Philosophy: Selected Texts with a Method for Beginners*. A light-hearted introduction to some key ideas in philosophy

(but not to particular thinkers) is Stephen Law's (2004) *The Philosophy Files*.

Oxford University Press publishes philosophy topics in its 'A very short introductions' series (see www.oup.co.uk/vsi): for example, Tony Hope's (2004) *Medical Ethics: A Very Short Iintroduction*, Martin Davies' (2005) *The Mind*, and Simon Glendinnings' *Derrida* (2005). Lively introductions with cartoon images are published by Ivan Borks, Cambridge, in their 'For Beginners' series; for example John Heaton and Judy Groves' (1994) *Wittgenstein for Beginners*. Routledge has published a series of weightier introductions in its 'Arguments of the Philosophers' series, for example, Peter Caws' (1979) *Sartre*.

Among earlier but still helpful introductions, is Thomas Nagel's (1987) *What Does it All Mean? A Very Short Introduction to Philosophy*, which covers the main themes in modern philosophy for the 'complete beginner'. Slightly more extended is Martin Hollis' *Invitation to Philosophy* (1985, reprinted 1992). Anthony O'Hear's (1985) *What Philosophy Is* gives a more formal account.

Succinct 'lecture notes' covering each of the main areas of modern philosophy (i.e. philosophy of science, philosophy of mind, ethics, etc.) is William James Earle's (1992) *Introduction to Philosophy*. An edited collection with contributions from a wide range of philosophers on each of the main problems of philosophy (free will, mind, and body, etc.; also two chapters on political philosophy) is *Key Themes in Philosophy* edited by A. Phillips Griffiths (1989). A companion volume providing an introduction to classic texts is *Philosophers Ancient and Modern*, edited by Godfrey Vesey (1986). A highly readable introduction to recent French philosophy is Eric Matthews' (1996) *Twentieth Century French Philosophy*.

There are many large dictionaries and encyclopaedias that offer helpful introductions to key topics in philosophy and to individual philosophers. Examples include, *The Oxford Companion to Philosophy*, edited by Honderich (1995), *The Oxford Dictionary of Philosophy*, edited by Blackburn (1994), and *The Cambridge Dictionary of Philosophy*, edited by Robert Audi (1995 second edition, 1999). Edwards and Pap's (1973) *A Modern Introduction to Philosophy* although now somewhat dated, gives key readings from classical as well as contemporary sources. James Rachels' (2005) *Problems from Philosophy* provides an authoritative and fully contemporary introduction. The Blackwell 'Companions' series gives collections of key papers in each main area of philosophy, ethics, aesthetics, political philosophy, logic, philosophy of science, philosophy of mind, etc. Routledge's *Dictionary of Twentieth Century Philosophers* (ed. S. Brown, D. Collinson, and R. Wilkinson; 1996) includes biographies and reading guides to many of the great philosopher-psychologists of the nineteenth and early twentieth centuries. Bryan Magee's (1987) *The Great Philosophers* is the transcripts of a series of television programmes in which contemporary great philosophers talk about the work of earlier great philosophers (e.g. Geoffrey Warnock on Kant and Hubert Dreyfus on Husserl, Heidegger and modern existentialism).

Textbooks of psychiatry

A wide range of introductions to psychiatry is available, of varying lengths and aimed at mental health practitioners with different levels of experience. Among Oxford textbooks, three books of increasing length and detail are: (1) the *Concise Oxford Textbook of Psychiatry* (Gelder, Gath, and Mayou, 1994) primarily for medical students; (2) the *Shorter Oxford Textbook of Psychiatry* (Gelder, Mayou, and Cowen, 2001) giving more detail and aimed at trainees; and (3) the two-volume multi-author *New Oxford Textbook of Psychiatry* (Gelder, Lopez-Ibor, and Andreasen, 2000). The latter is edited by an international team—Michael Gelder (Oxford), Nancy Andreasen (USA), and Juan Lopez-Ibor (Spain)—and includes succinct authoritative chapters by world experts on all the key topics in psychiatry.

A recent introductory text for medical students and psychiatric trainees, covering all the core topics of general psychiatry, but also aiming to make psychiatry 'come alive' with a wealth of quotations, literary extracts, and artwork highlighting the experience of mental illness, is Neel Burton's (forthcoming) 'Psychiatry' (Note: Fulford is Editorial Advisor for this book.)

More specialized, but providing authoritative introductions to key areas are: (1) for old age psychiatry, Jacoby and Oppenheimer's (1996) edited collection *Psychiatry in the Elderly*; (2) for neuropsychiatry, Lishman's (1997) *Organic Psychiatry*; (3) Williams and Kerfoot's (2005) *Child and Adolescent Mental Health Services: Strategy, Planning, Delivery, and Evaluation* (this book is unusual in combining management and practitioner perspectives); Hawton, *et al.*'s (1989) *Cognitive Behavioural Therapy for Psychiatric Problems*; and for forensic psychiatry, there are two core texts in the UK literature, Bluglass and Boden's (1990) *Principles and Practice of Forensic Psychiatry*, and Gunn and Taylor's (1993) *Forensic Psychiatry: Clinical, Legal and Ethical Issues*.

The World Psychiatric Association publishes volumes reflecting different perspectives from around the world in its series on Images in Psychiatry, for example Okasha and Maj's (2001) *Images in Psychiatry: An Arab Perspective*.

The philosophy of psychiatry

Introductions and historical context

The explosion of new work in the interdisciplinary field between philosophy, psychiatry, and abnormal psychology, in the 1990s, is described and set in its historical context in Fulford, Morris, Sadler and Stanghellini's (2003a) introductory chapter to the launch volume to this series, *Nature and Narrative* (Fulford, Morris, Sadler, and Stanghellini, 2003b). Nature and Narrative, together with another volume in the series, Jennifer Radden's (2004) edited *Companion*, both include chapters by many of the recent contributors to the field and

between them cover most of the current key topic areas. We note examples from both these sources in later Reading Guides. A succinct account of key topics, linked to the curriculum of the Royal College of Phyciatrists, is Sandy Robertson's (2004) '*Philosophy and History of Psychiatry*'. A special issue of the *International Review of Psychiatry*, edited by Matthew Broome and Paul Bebbington (2004) from the Institute of Psychiatry in London, covers a range of cutting edge topics including developments in psychopathology and psychotherapy since Jaspers (Bolton, 2004), Merleau Ponty's phenomenology and psychiatry (Matthews, 2004), a conceptual framework for studying emotions (Hacker, 2004), the implications of automatism for moral accountability (Levy and Bayne, 2004), Wittgenstein and the limits of empathic understanding (Thornton, 2004), the need for an 'engaged epistemology' for understanding the clinical concept of delusion (Gipps and Fulford, 2004), and an article on reconceiving delusion (Stephens and Graham, 2004).

An early edited collection, based on a series of lectures organized by the Royal Institute of Philosophy in London, is Phillips Griffiths, A. (ed.) (1995) *Philosophy, Psychology, & Psychiatry*. The introduction and first chapter of this book describe the historical context of the renewal of the cross-disciplinary field (Fulford, 1995a, b). In their *Past Improbable, Future Possible*, the opening chapter of *Nature and Narrative*, Fulford *et al.* (2003a) set these developments in the context of developments in both philosophy and psychiatry in the twentieth century, linking Jaspers' work during psychiatry's first 'biological phase' with modern philosophy of psychiatry as part of psychiatry's second biological phase. As noted in that chapter, although strong traditions of interdisciplinary work between psychiatry and phenomenological and other 'Continental' philosophical traditions, were maintained throughout the twentieth century, philosophical issues in mental health, with the notable exception of studies (mainly critical) of psychoanalysis, were largely ignored by the analytic philosophers of Britain and North America. The potential for work in this area was certainly recognized, notably by Austin (1956/7), to whose 'philosophical fieldwork' we return later in this part, and by the American philosopher, Stephen Toulmin (1980): and there were occasional trail-blazing publications—Jonathan Glover's (1970) 'Responsibility' for example, drew deeply on careful work in different areas of psychopathology. But it was otherwise not until the late 1980s that publications began to appear regularly in the cross-disciplinary field.

Early 'new wave' publications

Early contributors to the current renewal of the field have been concerned with issues in specific areas of psychopathology (Wilkes, 1988; Spitzer *et al.*, 1993; Radden, 1996; Sass, 1994, 1995); but other topics have included concepts of disorder (e.g. Fulford, 1989), the scientific status of psychiatry (e.g. Reznek, 1991), the nature of personal identity (e.g. Glover, 1988), the relationship between psychiatry, philosophy of mind, and neuroscience (Hundert, 1989), and so forth. Indeed there are few areas of philosophy that have not turned out to have rich interconnections with problems in clinical work or research in psychiatry. The constraints on and potential links between philosophy and practice in mental health are discussed in detail, respectively, in chapters 1 and 12 of Fulford's (1989) *Moral Theory and Medical Practice*.

Illustrative topics in the cross-over area between psychiatry and the philosophy of mind are brought together in George Graham and G. Lynn Stephens' (1994) edited collection, *Philosophical Psychopathology*. A corresponding collection with a number of excellent articles broadly in the area of the philosophy of science is Sadler *et al.*'s (1994) *Philosophical Perspectives on Psychiatric Diagnostic Classification*.

Journals and book series

The French journal, *L'Evolution Psychiatrique*, has maintained a long-standing tradition of publications in phenomenology, philosophy, and psychiatry. In English, the journal *Philosophy, Psychiatry, & Psychology,* which is available on-line as well as in hard copy, publishes peer-reviewed original contributions with commentaries from different disciplinary perspectives, and responses to the commentaries by the authors. The *History and Philosophy* section of *Current Opinion in Psychiatry* (also available on-line), gives update review articles. A growing number of publications are appearing in mainline journals in both mental health and in philosophy (for literature search resources, see below).

Among book series, in addition to Oxford University Press' *International Perspectives in Philosophy and Psychiatry*, to which this book is a contribution, there is a growing international literature, including *Disorders in Mind: Philosophical Psychopathology*, from MIT Press, edited originally by George Graham and Owen Flanagan, and now by Jennifer Radden and Jeffrey Poland, Gerrit Glas' series in Dutch, the *Psychiatry and Philosophy* book series from Boom Publishers in Amsterdam, a series from Martin Heinze's group in Germany, the GPWP (Gesellschaft für Philosophie und Wissenschaften der Psyche), and from France a new review published by PSN–Edition in Paris, *Psychiatrie, Sciences Humaines et Neurosciences*.

Web-based resources

The philosophy of psychiatry

There are a number of web-based resources for the philosophy of psychiatry.

Centrally, the online version of all but the first 2 years of *Philosophy, Psychiatry, & Psychology* is available on subscription at: http://muse.jhu.edu/journals/philosophy_psychiatry_and_psychology. The contents can be searched online and articles downloaded. Each issue of *Philosophy, Psychiatry, & Psychology* includes a listing of new publications in the area in

its section on *Concurrent Contents: Recent and Classic References at the Interface of Philosophy, Psychology, and Psychiatry*.

Metapsychology offers a list over 2500 reviews of books published in the area and sorted by subject matter at: http://mentalhelp.net/books; and the main site for metapsychology, run By Christian Perring is at: http://www.angelfire.com/ny/metapsychology/

There is a long-standing bulletin board for philosophy of psychiatry announcements also run by Christian Perring at: http://health.groups.yahoo.com/group/philosophyofpsychiatry-announcements

A searchable on-line database of articles and books, developed originally by Paul Sturdee, and extended and now maintained by Richard Gipps, is being set up by the INPP (the International Network for Philosophy and Psychiatry) at www.inpponline.org.

Philosophy

The Philosophers Index is the 'MEDLINE' of philosophy, listing articles and books by subject and author. It is a subscription service and is available through universities and at 'Athens', http://www.athens.ac.uk

There is a free Internet Encyclopedia of Philosophy at: http://www.iep.utm.edu

The Philosophy Research Base contains links to the home pages of academic philosophy departments around the world, plus homepages of many living philosophers: http://www.erraticimpact.com/homepages/home_page_index.htm

The Society for Applied Philosophy provides a focus for philosophical research with a direct bearing on areas of practical concern, including environmental and medical ethics, the social implications of scientific and technological change, philosophical and ethical issues in education, law and economics. http://www.sas.ac.uk/philosophy/sap

Psychology and medicine

Databases, available by subscription through Athens (http://www.athens.ac.uk), include:

- MEDLINE which indexes a large proportion of the leading journals in the medical and health fields from 1965 onwards, and
- PsycInfo which covers psychological literature from 1887 to present day, including journal articles, books, book chapters, technical reports, and dissertations published in over 45 countries.

Online resources include:

- Psychnet, which is run by the American Psychological Association, has a good site map and dedicated search engine for psychology resources on the web. http://www.apa.org/topics/homepage.html
- The Psychology Virtual Library keeps track of online information as part of The World Wide Web Virtual Library. Sites are inspected and evaluated for their adequacy as information sources before they are linked from here. http://www.clas.ufl.edu/users/gthursby/psi/
- Cogprints, which contains archived papers in psychology but also neuroscience, linguistics and philosophy. While coverage is limited it contains some very high quality work. http://cogprints.org

Concepts of disorder: (1) The debate about mental illness

An early but still valuable review of various theories of the nature of mental illness is Anthony Clare's (1979) 'The disease concept in psychiatry' (in *Essentials of Postgraduate Psychiatry*, edited by P. Hill, R. Murray, and A. Thorley). Among classics in the early debate are Laing's *The Divided Self* (1960), Scheff's (1974) and Rosenhan's (1973) work on labelling, and Foucault's (1965) political analysis. Social constructionist models are reviewed in Church (2004). Lewis (1953) gives an early analysis of mental disorder as being distinguished by disturbance of part-functions. Many of the most important classic papers in the debate about mental illness are to be found in the edited collection: *Concepts of Health and Disease*, ed. A.L. Caplan, T. Englehardt, J.J. McCartney (1981). These reviews are brought up to date by Fulford in an entry on 'Mental Illness', for Chadwick, R. (ed.), *The Encyclopedia of Applied Ethics* San Diego, Academic Press (1998); and an article on 'Mental Illness: Definition, Use and Meaning', for Post, S.G. (ed), *Encyclopaedia of Bioethics* (2003); and by Gert and Culver (2004) in *Defining Mental Disorder*.

The Department of Health and Society at Linköping University in Sweden has published a number of books on concepts of disorder and mental health. In addition to Nordenfelt's work (see Chapter 6), examples include Per-Anders Tengland's (1998) *Mental Health: a Philosophical Analysis*, Per Sundström's (1987) *Icons of Disease*, and Tommy Svenson's (1990) *On the Notion of Mental Illness*. Other contributions from a rich Scandinavian literature include Uffe Juul Jensons' (1987) *Practice & Progress*; Henrik Wulff, Stig Andur Pedersen, and Raben Rosenberg's (1986) *Philosophy of Medicine*, and Louhiala and Stenman's (2000) *Philosophy meets Medicine*.

Matthews (1999a) explores the boundary between morals and medicine in *Philosophy, Psychiatry, & Psychology* in his 'Moral Vision and the Idea of Mental Illness', with commentaries by Spitz (1999) and Benn (1999), and a response (Matthews, 1999b). Margree (2002a) opens up a neglected resource for work in this area in her *Normal and Abnormal: Georges Canguilhem and the Question of Mental Pathology*, with a commentary by Gane (2002) and a response (Margree, 2002b).

A detailed analysis of the similarities and differences between anti- and pro-psychiatry theories of the concept of

mental illness, together with the arguments leading to the redefinition of the terms of the debate as set out in this chapter, is given in chapter 1 of Fulford's (1989) *Moral Theory and Medical Practice*. The central place of psychotic disorders in the conceptual map of mental disorder is described in chapter 10 of this book. The 'map' of mental disorders in Session 2 was first published in Fulford (1993).

The terms of reference of the debate about mental illness are challenged by Pickering (2003a and b) in his article in *Philosophy, Psychiatry, & Psychology* on the 'Likeness argument and the reality of mental illness', with commentaries by Gipps (2003) Loughlin (2003), Mullen (2003), and Tyreman (2003), and more fully in Pickering (2006). Ian Hacking (1998) explores the influences of cultural factors on the form of mental illness through a richly illustrated historical narrative in his *Mad Travellers*.

Szasz (1987) has drawn together the themes of his work in *Insanity: the Idea and its Consequences*, which includes a full bibliography. A brief but highly readable critique of Szasz' position, including its implicit dualism, is a book by Sir Martin Roth, a former President of the Royal College of Psychiatrists in the UK (and Honorary President of the Philosophy Special Interest Group in the Royal College of Psychiatrists), and Jerome Kroll, a distinguished Professor of Psychiatry in the USA (and a founding member of the American Association for the Advancement of Philosophy and Psychiatry), called, simply, *The Reality of Mental Illness* (1986). A recent collection on Szasz and his critics (with replies by Szasz) is Schaler's (2004) *Szasz Under Fire*; this includes Fulford's (2004) *Values-Based Medicine: Thomas Szasz's Legacy to Twenty-First Century Psychiatry*, which links Szasz' work to recent developments in policy and practice in mental health.

Models of disorder, patient-centred practice and multidisciplinary teams

Although the debate about models of mental disorder is less high profile than it was in the 1960s and 1970s, this is because the issues have now found their way through into policy and practice through developments aimed at, (1) giving the 'user voice' an increasingly central role in all areas of mental health, including research, and (2) reorganizing services around multidisciplinary and multiagency approaches. The importance of both user-centred and multidisciplinary approaches to contemporary service delivery are emphasized, for example, in a national policy document underpinning mental health service provision in England and Wales, the *National Service Framework for Mental Health* (Department of Health, 1999) with direct practical applications in areas such as recovery practice (Allott *et al*., 2002).

A user-friendly introduction and an integrated approach to the main models of disorder important in clinical work in psychiatry is Tyrer and Steinberg's (2005) *Models for Mental Disorder*. The different perspectives (biological, psychological, and social) important in psychiatry are carefully set out by McHugh and Slaveny (1983) in *The Perspectives of Psychiatry*. The medical model in psychiatry is well reviewed by Macklin (1973) in *The Medical Model in Psychoanalysis and Psychotherapy*.

For a discussion in *Philosophy, Psychiatry, & Psychology* of the applications of Foucault's philosophy to modern user-led developments in service delivery, see Bracken's (1995) *Beyond liberation: Michel Foucault and the Notion of a Critical Psychiatry*, with commentaries by Kendall (1995), Matthews (1995), Heinze (1995), and Kovel (1995). Bracken (2001) and Bracken and Thomas (2001 and 2005) explore the role of post-modern thinking generally for models of service delivery in mental health.

Indications of the practical importance of models of disorder especially in the new circumstances of community care are to be found in, (1) a large literature from patients and patient groups: e.g. Campbell's (1996) *What We Want from Crisis Services*; (2) more systematic studies: e.g. Rogers, Pilgrim, and Lacey's (1993) *Experiencing Psychiatry*; (3) official reports, e.g. the *Report of the Clinical Standards Advisory Group on Schizophrenia* (HMSO, 1995)—this showed that an over-reliance on a consumer-led model could lead to seriously ill patients being neglected; and (4) the ethical and clinical problems posed by community care: e.g. Perkins and Repper's (1998) *Dilemmas in Community Mental Health Practice*. Chapter 11, on *Interprofessional Relations*, of the BMA's (1993) *Medical Ethics Today* is a helpful review of the ethical issues arising in multidisciplinary team working. Fulford, Stanghellini's, and Broome (2004) *What can Philosophy do for Psychiatry?* gives an overview of the role of philosophy in relation to these developments. The *Declaration of Madrid*, the first code of psychiatric ethics to spell out the importance of the 'user' voice in clinical decision-making, was published by the World Psychiatric Association, Geneva (1996).

Anthony Colombo's (1997) *Understanding Mentally Disordered Offenders: a Multi-Agency Perspective* describes an empirical study of the role of different implicit models of disorder in structuring practice. This includes operationalized definitions of each of the key models, medical, social, etc. Anthony Colombo has applied his models methodology to multidisciplinary team working in Colombo *et al*.'s (2003a) 'Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multidisciplinary teams'. This study showed wide differences of implicit models between psychiatrists, social workers, community psychiatric nurses, patients, and carers. An overview of this work is given in *Openmind*, the journal of the UK user advocacy organization, Mind (National Association for Mental Health) (Colombo, *et al*., 2003b). The philosophical roots of the study in linguistic-analytic philosophy are set out in Fulford and Colombo (2004). The findings from the study and methods developed are included in the training materials for values-based practice described in Chapter 21.

Although biological and other approaches to mental distress and disorder are often presented as being mutually exclusive, among the best of the exponents of different approaches are many who recognize the need for different and complementary models in mental health if the discipline is to serve the diverse needs of individual patients: thus, David Healy's (1990) *The Suspended Revolution*, argues this point from the perspective of psychotherapy, while Nancy Andreasen's (2001) *Brave New Brain* makes the same point from the perspective of the new neurosciences.

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