CHAPTER 6

# Philosophical outputs in mental health practice and research

## Chapter contents



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Thus far in this part we have considered the kinds of problem characteristically tackled by philosophy (Chapters 2 and 3) and philosophical methods (Chapters 4 and 5). In this chapter we will be thinking about the outputs from philosophical work, about what we should expect to get out of doing philosophy.

It is important to spend some time on this. Views about the value of philosophy (whether indeed it has any discernible worthwhile outputs at all!) are as diverse as views about philosophical problems and philosophical methods. As we will see, they range from the overoptimistic to the overpessimistic. So we need to get a balanced perspective appropriate to the particular contingencies of philosophy and mental health.

It is with this balanced perspective on the outputs from philosophy that we are concerned in Session 1 of this chapter. Our broad conclusion in Session 1 is that philosophy gives us a more complete view of the meanings of the concepts by which we structure and make sense of the world. It is, as a former Professor of Psychiatry at the Institute of Psychiatry in London, Sir Denis Hill, once put it, a 'consciousness raising exercise' (D. Hill, personal communication, 1976). In Sessions 2–4, we then go on to show how philosophy gives us a more complete understanding of the medical concepts than that offered by the traditional medical model: philosophy adds, respectively, values to the facts emphasized in the medical model (Session 2), illness to disease (Session 3), and action to function (Session 4).

The end result, it is important to emphasize, is not to diminish or undermine the importance of science in medicine, as reflected in the traditional medical model. To the contrary, everything that is genuinely scientific about medicine remains intact and is indeed clarified. The end result, rather, is an enriched model in which human and scientific aspects of the discipline—values besides facts, patients' experiences of illness besides medical knowledge of disease, and loss of personal agency besides disturbances of bodily and mental functioning—are fully and equally represented.

## Session 1 'I wonder if this headache is mine?'

For many people, philosophy is an arcane discipline, at best self-indulgent, at worst self-deluded. The cartoon in Figure 6.1 sums up the popular image of the philosopher. Most people just have headaches. This philosopher is asking whether his headache is his!

This cartoon appeared in the course book to a programme in philosophy run over 30 years ago by the Open University (a major provider of 'distance learning' programmes in the UK). Intended ironically it none the less illustrates some important points about the value of philosophy.

**EXERCISE 1** (15 minutes)

Think carefully about the cartoon in Figure 6.1. Taken as it is from an introductory course in philosophy, it was intended to illustrate the difference between philosophical and non-philosophical questions.

- How *practical* is the question this philosopher is asking?
- What might you get out of thinking about it?
- Could you go to the Medical Research Council (one of the major funders of medical research in the UK) for support to do research on this question? If not, why not?

Write down your own answers to these questions before going on.

### The self-evident and the practical

On first inspection, the cartoon is a comment on the pointlessness of philosophical questions, and this is often how it is taken. Whoever needs to ask if the headache they feel is their own! That a headache is one's own headache, surely, is all too painfully self-evident.

Well, we will see especially in Part V, that the 'ownership' of experiences is, on the one hand, one of the deepest and longest running of metaphysical questions, and, on the other, crucially relevant to mental health practice (the symptom of 'thought-insertion', in schizophrenia, described in Chapter 3 provides one of the clearest examples of the remarkable *separation*, in this condition, between first-personal experiences and the sense of ownership of those experiences).

We return to thought insertion in Chapter 30 at the end of Part V. But the point for now, and a key point to take from the Open University's cartoon of the philosopher with a headache, is

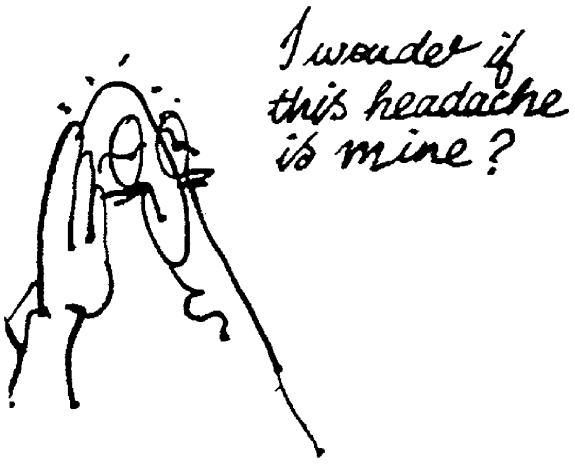


**Fig. 6.1**

that philosophers, in asking questions that others may think pointless, because self-evident, may often be asking questions that are highly practical when it comes to navigating in the conceptually tricky waters of mental health.

Questions of this kind, however, often do seem entirely pointless to 'practical' people. To the busy doctor, it may seem that they have problems enough without raising questions about the (apparently) self-evident. The Medical Research Council is unlikely to commit its increasingly scarce resources here! Of course, *ethics* has come into its own since the time of the Open University cartoon. A practical 'bioethics' is now widely accepted as being essential to good practice in all aspects of health care. In some ways, though, the success of ethics has increased, rather than decreased, the distance between philosophy and everyday practice.

### Ethics, yes! Philosophy, no!

The continuing separation between philosophy and practice, notwithstanding the growth of bioethics, is illustrated by another cartoon, from a more recent publication, shown in Figure 6.2.

This cartoon appeared on the cover of an issue of the *Drugs and Therapeutic Bulletin* in 1996 dedicated to ethical dilemmas. The *Bulletin* is distributed to all medical practitioners in the UK as an update service. That an issue should be devoted to ethics, unthinkable even a few years ago, shows how far the subject has come. The cover cartoon, however, points a warning finger at 'philosophy'. The suggestion is that there is a difference between asking for a doctor (who could do something practically useful) and asking for a philosopher (who, the cartoon implies, could not.)

And of course in circumstances of this kind, the philosopher, *qua* philosopher, should certainly get smartly out of the way of the first aid crew. For in circumstances of this kind, the problems are indeed primarily empirical rather than conceptual. The problems are the empirical problems of deciding what is wrong and of doing something decisive about it. The problems are not the conceptual problem of deciding whether the condition of the person in the cartoon (lying collapsed on the floor) is properly understood as a medical condition. For precisely this reason, then, because the problem is not a philosophical problem, what is needed when someone has collapsed, is a first aid crew not a philosopher. But what gives the cartoon its point (an ironic point, no doubt) is the implication that philosophers may have *any* role to play in medicine.

### The self-evident and the practical

As with all academic subjects, philosophy is not justified primarily by being practically relevant. It may, legitimately, be pursued for its own sake; as may poetry or mathematics, or, indeed,


*"Is there a philosopher in the house?"* **Fig. 6.2**

biochemistry or economics. Some philosophers, though, the counterparts of those practitioners who assume that philosophy is point*less*, believe that doing philosophy for any reason other than for its own sake is a form of intellectual prostitution.

That you are reading this book—whether as a philosopher or practitioner—suggests that you sense there may be something of value in linking philosophy and practice. We will see in this session that part, at least, of the value of bringing the disciplines together consists *just in questioning the (apparently) self-evident*. We will come to this conclusion, though, by way of the (very divergent) views of philosophers themselves as to what we should expect from philosophy. As we will see, some philosophers have been unduly pessimistic about the value of philosophy, others unduly optimistic. Somewhere in between will be the point of balance.

## Philosophers manic . . .

The antipsychiatry movement (Chapter 2) was in part a response to psychiatrists claiming too much, or at any rate to their having had too much claimed for them on their behalf. This was Szasz's concern, you will recall; and it was shared by many of those less inimical to the subject—the starting point for Boorse's work, for example, was a concern about the 'medicalisation' of morals, about more and more of the human condition being assimilated to psychopathological categories.

Antiphilosophical sentiment, similarly, is in part a response to philosophers having claimed too much. Plato (in *The Republic*) wanted to make philosophers kings; philosophy, traditionally, has been acclaimed the queen of the sciences; and the philosophical project has often been conceived as foundational, its aim being to establish the foundations for other (and by implication, secondary or derivative) subjects.

### The last great philosopher?

One of the last great philosophers to take this perhaps rather manic view of the value of philosophy was the young Bertrand Russell (Figure 6.3). With a colleague at Cambridge, A.N. Whitehead, he set out to establish the foundations of mathematics in logic. After years of work, and initially at Russell's expense, they published the monumental *Principia Mathematica* (in 1903).

Shortly after this, Russell wrote an introduction to philosophy, aimed at the general reader, *The Problems of Philosophy* (1912, with numerous reprints). This deals mainly with problems in the theory of knowledge, but in the concluding chapter Russell draws together his views about the value of philosophy.

**EXERCISE 2** (30 minutes)

Read the extract from:

Russell, B. (1912). The value of philosophy. *The Problems of Philosophy*. London: Williams and Northgate, pp. 237–250

Link with Reading 6.1

**Fig. 6.3** Bertrand Russell

- How does Russell conceive the difference between philosophy and science in terms of their practical value?
- What claims does he make for the practical value of philosophy?

Make a note of these claims as you read the chapter. Some are more grandiose than others. For each claim, think what its practical value might be for mental health (practice or research).

Writing in the early 1900s, a less materialist era than our own perhaps, it is clear that Russell had experienced the antiphilosophical sentiments expressed in the cartoons at the beginning of this session. He is dismissive of the 'many men' who 'under the influence of science or of practical affairs' consider philosophy to be '. . . useless trifling, hair-splitting distinctions and controversies on matters concerning which knowledge is impossible'. Such 'practical men', wrongly so called, as he says, fail to recognize that 'the goods of the mind are at least as important as the goods of the body'.

### 'Goods of the mind' and thinking skills

It is in contributing to the 'goods of the mind', then, that philosophy has value (in Russell's account), at least for those who study it; in contrast to science, which, in contributing to the 'goods of the body', may also be of value to those who are wholly ignorant of it.

Well, there is something in this contrast, of course. But in mental health, the 'goods of the mind'—improved thinking skills, as we indicated in Chapter 1, may be of very real value to others through improved practice. And improved thinking skills certainly seem to have been among the goods that Russell had in mind. Philosophy, he says, provides knowledge of the kind '... which results from a critical examination of the grounds of our convictions, prejudices and beliefs' (p. 239). This last phrase would not look out of place among the aims of an (enlightened) training programme in any area of mental health! We will see later in the book that the lack of just such a critical examination has been an important factor leading to abusive practices in psychiatry (for example, in Part IV).

### 'Goods of the mind' and 'grand unifying theories'

Russell's other main claim for philosophy, on the other hand, would look distinctly odd among such practical aims. Philosophy, he suggests (also on p. 239) is concerned with '... the kind of knowledge which gives unity and system to the body of the sciences ...'.

To the modern ear this claim has a distinctly grandiose ring. Indeed, although entertained in one form or another by philosophy in many periods of its history, it has been largely abandoned since Russell wrote these words. Philosophers, nowadays, far from being concerned with 'unity and system', perceive themselves as working piecemeal and opportunistically. It is theoretical physics, ironically, which now claims a *Grand Unified Theory* as its goal!

One reason for this is cultural. Ours is not an age of heroes. We are embarrassed by Russell's talk of philosophical contemplation leading to 'greatness of soul', of the 'free intellect' seeing 'as God might see'; of the 'unalloyed desire for truth', a quality of mind 'which, in action, is justice, and in emotion ... universal love'. Perhaps we should not be embarrassed by these phrases. We have an urgent, and most practical, need for idealism, not least in mental health. But as claims for philosophy, these would cut little ice with a modern psychiatric training committee or research panel.

A second reason for the abandonment of philosophy's loftier ambitions is its (apparent) failure to make progress. This is foreshadowed by Russell. It must be admitted, he acknowledges, that compared with science, mathematics, or even economics, philosophy is long on questions and short on answers. This is partly because when a subject matures to the point where definite answers become possible, it stops being philosophy—astronomy, physics, and, most recently, psychology, have been lost to philosophy (J.L. Austin talked of them being 'kicked upstairs'). But this has still left the big questions at the heart of philosophy's agenda as open as ever: the nature of consciousness, good and evil, free will, the purpose of life, the possibility of knowledge....

A third reason comes from within philosophy itself, namely proof positive that foundations, at least as traditionally conceived, are not to be had, that, to the contrary, uncertainty goes all the way down. Two figures stand out head and shoulders above other twentieth century philosophers in the discovery of this radical uncertainty. The first is Ludwig Wittgenstein, the Austrian-born Cambridge philosopher, to whose work we return in a moment. The second is the Austrian philosopher and logician, Kurt Gödel (Figure 6.4). The nub of Gödel's extraordinary insights is that there are no foundations to be had even for mathematics, let alone philosophy. Contrary to Russell and Whitehead's claims, Gödel showed that any mathematical system sufficiently complete to allow the basic procedures of addition, subtraction, multiplication, and division, must contain statements that are fully meaningful within the system, yet the truth or falsehood of which can be determined only by going up a level to a more complex system. But then there will be 'Gödel-undecidable' statements at this next level up; and so on, *ad infinitum*.

**Fig. 6.4** Kurt Gödel

### Radical uncertainty: a win–win situation?

Gödel's work, being in philosophical logic, is not well known outside philosophy. But the discovery of radical uncertainty is a win–win result for both philosophy and mental health.

In philosophy, it shows that, contrary to the common perception, philosophy really does make progress—not the progress it expected, perhaps, but progress none the less. After centuries of working towards foundations, philosophy itself has shown that it has been chasing a rainbow. But this means that philosophy has turned out to be falsifiable, much as science—in the model of another great philosopher of the twentieth century, Karl Popper—is falsifiable (we return to Popper's work in Part III). And more than this, philosophy has turned out to be falsifiable through the careful accumulation of argument and counter-argument. Gödel was Russell's bane: he showed that Whitehead and Russell's *Principia Mathematica* (1910) was fatally flawed; and

Russell in turn was the bane of the great nineteenth century German philosopher of mathematics Göttlob Frege. Put this sequence in the positive, however, and we see that Russell and Whitehead built on Frege's work, and Gödel in turn built on Russell and Whitehead's work.

The discovery of radical uncertainty is also a 'win' for mental health because it goes to the heart of what one of us has called the 'pathologies of certainty' by which the subject was plagued throughout the twentieth century (Fulford, 2000). Time and again, the most adverse developments in mental health over this period have been driven, not by lack of knowledge, still less by ill intention, but by false certainties, by the all-too-sincere conviction of this group or that, often of particular individuals, that they have *the* answer—psychoanalysis, social psychiatry, anti-psychiatry, and, latterly, biological psychiatry, have all fallen prey to becoming overblown. We will return in a moment to the positive side of philosophy's contribution to mental health, but this, at least, is crucial—it helps us develop a mind set that, avoiding false certainties, is open, reflective, and responsive to change.

## . . . and philosophers depressive

Russell was well aware of the value of uncertainty and of the importance of philosophy in helping to avoid false certainties. Russell (1912) indeed sees this as central: 'The value of philosophy', he writes on p. 242, 'is, in fact, to be sought largely in its very uncertainty'. And it is uncertainty of the kind Russell had in mind, which is crucial to mental health: in everyday clinical work, it is the 'arrogant dogmatism' (Russell's phrase) of the practitioner unreflectingly convinced that his or her approach is best, which is at the heart of much abusive practice (we look at this in detail in Part IV); and in research, 'confining ourselves to definitely ascertainable knowledge' although good for one's CV, and attractive to funding agencies, undoubtedly stifles 'that speculative interest' which is the mainspring of innovation.

It is perhaps natural, none the less, that with his monumental *Principia Mathematica* so quickly overtaken by Gödel, Russell should have adopted a far less grandiose vision of the role of philosophy in his later work. Certainly he was not alone among twentieth century philosophers, faced with the apparent failure of their project, and unfavourable comparisons with science, in swinging from their long historical high to a distinctly depressive low. The extremes of this depressive reaction are illustrated by the following readings.

**EXERCISE 3** (10 minutes)

Read the brief extracts from:

Wittgenstein, L. (1921). *Tractatus Logico-Philosophicus* (trans. by D.F. Pears and B.F. McGuinness). London: Routledge and Kegan Paul, last page

Link with Reading 6.2

Russell, B. (1962). *An Inquiry into Meaning and Truth*. London: Penguin Books, p. 23

Link with Reading 6.3

Williams, B. (1985). *Ethics and the Limits of Philosophy*. London: Fontana Press/Collins, p. 23

Link with Reading 6.4

Think about how their respective views about the characteristic outcomes of philosophy stand up to the work we have done already in this part on the concept of mental illness.

Wittgenstein's essential point, in the first of these three readings, seems to be that the value of philosophy is to self-destruct. This extract comes right at the end of his first book (and the only one to be published in his lifetime), the *Tractatus Logico-Philosophicus* (1921). His pithy, aphoristic style, makes him very difficult to read. It can seem that there is no 'story-line'. In fact, this somewhat negative view of philosophy is a mark of continuity between the younger Wittgenstein and the later Wittgenstein, the author of the *Philosophical Investigations* (1953). It is in the later work that he makes explicit the view that philosophical problems are merely 'grammatical illusions', products of a 'bewitchment of our intelligence by means of language'. In effect, then, philosophical problems are artefacts of philosophy itself, to be *dis*solved (rather than solved) by taking us back to a clear (rather than philosophically befuddled) view of ordinary, non-philosophical, language use (remember this distinction, between ordinary and philosophical usage, introduced in Chapter 4). (On a recent interpretation of the *Tractatus Logico-Philosophicus* nearly every paragraph of that work is a sophisticated *reductio ad absurdum*; Crary and Read, 2000. The eventual conclusion of an intelligent reader is that although it seems to make sense, the *Tractatus* is really, strictly, a piece of nonsense. It does not advance meaningful philosophical claims.)

The outcome, though, the result, once we have this clear view, is the end of philosophy! Wittgenstein indeed thought for a while that he had finished (off) philosophy, that there was nothing left to do once this point had been recognized. Having climbed the rungs of the ladder, as he puts it in the extract you have just read, he did indeed push the ladder away. He went off for 10 years and worked as a gardener in a monastery.

### Grammatical illusions and mental health

Wittgenstein was hugely influential on philosophy in the second half of the twentieth century and we will see later that there are important truths in his conception of philosophical problems. But does his negative conclusion—that philosophical problems are, merely, illusions—stand up to our experience *in mental health*?

**Fig. 6.5** Wittgenstein

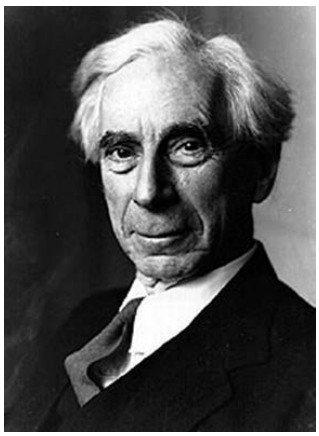

**Fig. 6.6** Russell

The debate about mental illness sprang up entirely outside philosophy, after all. So much so, that most of its most active participants were not philosophers—Szasz and Kendell, although drawing on philosophical ideas, were not philosophers. The debate, and the related debate about concepts of illness, disease, and so forth, arose not among philosophers but *within* ordinary usage. Those involved may, perhaps, have been under the influence of 'grammatical illusions': Szasz could be taken as saying that the concept of mental illness is one big grammatical illusion. All the same, the conceptual problems posed by the medical concepts, far from being artefacts of philosophical usage, are products of practical issues of the deepest urgency. And to the extent that philosophy can help with these issues, its outputs, correspondingly, will be practically relevant. Practical problems *in*, practical solutions *out*!

This is the relevant point also in reply to the extracts from Russell and Williams. Russell's picture of philosophers giving us a 'complicated structure' in place of what we take to be self-evident (that one has two eyes), comes in the introduction to one of his books on epistemology, or the study of knowledge. His ironic comment, that 'as to the value of this, he did not feel competent to judge', may be right for practically unimportant questions (about whether one has two eyes). But had he been concerned with practically *important* questions, his 'complicated structure' would have been correspondingly important practically. And how dramatically different in tone and temper are his claims for philosophy in 1962 compared with the claims he felt able to make as a young man 50 years earlier, in 1912.

## The mob and the moderates

Bernard Williams, a former White's Professor of Moral Philosopher at Oxford, has at times been positively dismissive of philosophy, at least of the analytic kind. Like many non-philosophers, he thinks the abstractions teased out by philosophers are powerless against the real world . . . in his evocative image, the Professor's arguments will be impotent when the mob 'break down the door, trample his spectacles, take him away'.

In relation to mental health, though, our reaction must be that if arguments fail, what have we left? It is after all the 'mob' that is our enemy. Of course arguments will fail against the fanatic. But aside from countering plain prejudice, it is critical to good practice in mental health that we recognize the subtleties, uncertainties, and complexities of the situations with which we are dealing day-to-day. In a later section we will look at the history of abusive practice in psychiatry. As already noted, we will find that a crucial factor in this, whether institutionalized as in the former Soviet Union, or sporadic, has been, not deliberate malpractice but the enthusiasms of those who are convinced that they have 'the answer'.

And this, after all, is Russell's point, in the extract from his 1912 book (Exercise 2), over again. At that stage in his philosophical development, as against the later extract, he was still confident of the value of philosophy, not in providing 'answers' but as a foil against false answers, against prejudice, against narrowness of view, against dogmatism. It is to this view, too, that he comes in his *History of Western Philosophy* (first published in 1946). This remarkable overview of philosophy, from its earliest beginnings

up to the early twentieth century, places each major figure in their historical and social context. And in his introductory overview (p. 14), Russell identifies the key task for philosophy, in our generation, as helping us to cut the umbilical cord of blind conviction and to learn to live with uncertainty.

### Gadflies get swatted

This is not a recipe for popularity, it should be said. The work we have done so far on the concept of mental illness, shows that neither extreme position, neither the manic nor the depressive view of the value of philosophy, is likely to be right, at least in respect of mental health. We have already come up with a Russellian more complicated structure (his phrase in the 1962 extract). So this will not please either kind of extremist! Moreover, because a more complicated structure *is* more complicated, it is not readily reduced to a slogan. There is no 'sound-bite' around which to rally. So it may seem that philosophy, to the extent that its value consists in showing us that the answers we thought we had are wrong, offers nothing in return.

Socrates, the 'gadfly' of Athens, paid the price for this. He was one of the manic philosophers. Where Wittgenstein, Russell, and Williams, in the above three extracts at least, are all depressives, adopting excessively pessimistic views of the value of philosophy, Socrates (as reported by Plato in *The Republic*) thought philosophy so important he would have made philosophers kings. In fact, so irritated were the Athenians by his capacity to show that everything they took to be self-evident was wrong, they ended up executing him. His arguments at his trial certainly had all the naïveté Bernard Williams so vividly portrays. Call that a defence! But it is a good example of what happens when the Bernard Williams' mob *do* break in.

## A more complete view

So far in this session, we have seen that philosophy is not the end of its own story, as Wittgenstein thought; it offers us a Russellian longer story; and *contra* Williams, in mental health at least, the recognition that there is a 'longer story', even if ultimately no defence against the mob, is in itself a contribution to good practice—it puts discursive argument in the path of dogma, reflection in the place of prejudice and presupposition.

In the remainder of this chapter, we will be looking in more detail at the 'longer story' itself, at the kind of story it is, and at its main elements. This will take us from the negative side of the role of philosophy in mental health, to its positive side.

**EXERCISE 4** (25 minutes)

Think about the account of philosophy's role given here, i.e. as giving us a more complete view, in relation to the work we have done in earlier chapters on the concepts of bodily illness and mental illness. Are the conclusions we reached there consistent with this account? Write brief notes on your conclusions before going on.

### Two incomplete views in Chapter 2

It was to a more complete view of the concepts of bodily illness and mental illness that we came in Chapters 2 and 4. Thus, in terms of our 'map' of psychiatry introduced in chapter 2, Kendell and the pro-psychiatrists focused on one side, the *fact* side, while Szasz and the antipsychiatrists focused on the other side, the *value* side. The arguments of both, however, were driven by an essentially 'medical' model in which genuine diseases are taken to be defined by 'value-free' scientific criteria. Hence Szasz, focusing on the value connotations of mental illness, concluded that it was a myth; while Kendell, focusing on its factual connotations, concluded that at least some mental disorders are genuine diseases. Both sides, therefore, were working with one-sided views of the concepts with which they were concerned.

### A one-sided view in Chapter 4

Boorse, in chapter 4, working primarily by careful definition, took a first step towards giving us a more complete view by introducing the distinction between illness and disease. However, his approach was still governed by a one-sided (or perhaps lopsided) view, to the extent that he sought to define disease, which he took to be the theoretical core of all things genuinely medical, in terms of the fact-side only.

So the whole debate, to this point, was dominated by one or other incomplete view, by the illusion that one or other side is, as it were, definitionally pre-eminent.

### Coming to a more complete view

In the remainder of this chapter we will be coming to a more complete view of the medical concepts: in Session 2 by adding values to the facts of the medical model; in Session 3 by adding the patients' experiences of *illness* to specialist knowledge of disease; and in Session 4 by adding an analysis of the experience of illness in terms of incapacity, or a particular kind of *failure of action*, to the analysis of disease in terms of failure of function.

As already emphasized, this will amount, not to abandoning the medical model, but to seeing its elements (facts, disease, failure of function) as parts, important parts to be sure, but still only parts, of the conceptual structure of health care. The traditional medical model as a whole, then, will, according to this line of argument, turn out to be a Wittgensteinian illusion or incomplete view.

### The power of the medical model

First, though, to pave the way for this, we will end this session by looking at just why the (Wittgensteinian) illusion of a value-free concept of disease should have been (and remains) so powerful and pervasive.

**EXERCISE 5** (30 minutes)

Think carefully about the 'medical' model in mental health. List as many examples of its continued influence as you can think of (if you are working in a group, this is best done in pairs, brainstorming a list for each pair and then combining your findings as a group).

Now make brief notes on three questions:

1. Why is this model so powerful and pervasive?
2. What are its strengths?
3. What would we lose if we gave up the idea that the medical concepts are value-free?

Once the 'medical' model is recognized for what it is—not a mistaken view, but a one-sided view—it is evident everywhere we look in mental health. The dominance of 'biological' psychiatry, in so far as it is conceived exclusively, is the 'medical' model writ large. But mechanistic interpretations of social and psychological psychiatry are one-sided in the same way.

The pre-eminence of the medical model is a natural consequence of the importance of science in medicine. Science has given us major advances in our understanding of the causes and treatments of illness. Hence it is natural that we should have come to focus on the factual element in the structure of medicine, that we should have taken disease concepts, and disease concepts developed in terms of disturbed functioning, to be, in some exclusive, or (as in Boorse's model) central way, its *defining* feature.

### Science plus

The more complete view, as introduced here, does nothing to undermine the importance of science in medicine. It suggests, only, that other elements are important also.

We have said this several times now and we make no apology for repeating it. It is crucially important to see from the start that what is involved here is not an overthrow of science. If this were the result of philosophical work in health care, it really would be a case of killing the goose that lays the golden eggs. Yet philosophy is still too often seen (and perhaps at times presents itself) as the enemy of science. This is sometimes true even of the new philosophical discipline of bioethics. But as we will see in Part IV, even in relation to values, the results of philosophical work in medicine are not to substitute for the illusion of a value-free (medical) model, an equally illusory fact-free model! (We will see in Part III, on the philosophy of science, that many would argue that science itself is far from value-free.)

Both kinds of element, then, fact *and* value, disease *and* illness, function *and* action, are important. Both are already there in the conceptual structure of health care and it is the task of philosophy, in giving us a more complete view, to make them explicit. This is the sense in which, in an earlier reading in this session, Wittgenstein said that philosophy 'leaves everything as it is' (Wittgenstein, 1953). But this is not the end of philosophy. In health care at least, making *both* kinds of element explicit is an important move, an Austinian 'first step', towards using *both* more effectively.

## 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. Is it good or bad practice to be concerned with apparently self-evident questions?
2. Some philosophers have been unduly optimistic about the contribution that their subject can make to practical disciplines: give one example of such a philosopher.
3. Whose work in particular burst the bubble of philosophy's traditional grand claims?
4. Other philosophers have been unduly pessimistic about the returns from philosophy for practical disciplines: give one example of such a philosopher.
5. How should we understand the practical pay-off from philosophy according to the view developed in this chapter?

## Session 2 Adding value to fact

In Chapter 4, we found that even Christopher Boorse, having defined 'disease' in value-free terms, was unable to sustain its use in a consistently value-free way. This suggested that there is an essential evaluative element in the meaning of 'disease'. In other words, however carefully Boorse (or anyone else) stipulates a purely descriptive or factual definition of 'disease', the term simply cannot do the work that is required of it in ordinary (i.e. technical as well as lay) usage if it is shorn of its evaluative meaning.

If this is true of 'disease', then, the most 'scientific' of the core medical concepts (and hence marked out by Boorse as the concept around which medical theory is to be built), it seems likely that despite (scientific) appearances, the medical concepts through and through are value concepts.

In this session, we follow up this idea by looking at some of the properties shared by all value terms in ordinary usage and applying these to the medical concepts. This will give us a quite different way of understanding the concept of 'bodily illness', and, hence, of interpreting the debate about 'mental illness'. We will come to some of the many practical implications of this later in the book (especially in Part IV).

## Agreeing and disagreeing about values

In the 1950s and 1960s, a number of philosophers, working mainly in Oxford and influenced by Austin, began to explore the properties of value terms in ordinary usage. We will be drawing on their findings in this session. They were not concerned with the medical concepts, still less with the debate about mental illness. But their observations are highly pertinent none the less.

To get into the spirit of their work, and to provide us with a basis from which to come back to the debate about mental illness, try the following brief exercise.

**EXERCISE 6** (20 minutes)

Make two lists of objects, events, sensations, or any other category of things that may be evaluated as good or bad:

1. The first list should be of things about which most people *agree*, evaluatively speaking (i.e. if one person thinks something is a good example of its kind, most other people will, and vice versa).
2. The second list should be of things about which people characteristically *disagree* (i.e. if one person thinks something is a good example of its kind, the next person may well think that it is a bad one, and so on).

An example for the first list would be eating apples—most people agree that a good eating apple is crisp, sweet, and clean-skinned. An example for the second list would be pictures—people tend to disagree about what makes a good picture.

If you are working in a group, try this in pairs. Once you have got two lists (of, say, half a dozen items each), consider what it is exactly that you are agreeing about for list 1 and disagreeing about for list 2. Write down your conclusions.

This can be a surprisingly difficult exercise, especially working on your own. Before we think directly about the two lists, it will be worth looking at why this should be.

### Two reasons why this exercise is difficult

One reason why this exercise is difficult is because values are built so deeply into the way that we think about the world, we take them for granted. This will be an important observation later, especially in Part IV, when we examine the values that govern practice in mental health and the extent to which they have remained largely covert.

A second reason for the difficulty of this exercise is that it is set up, deliberately, in a very open way. A natural reaction, on starting to think about agreement or disagreement on questions of value, is to say '*value for what?*'. Again, this is an important observation. There are different kinds of value—aesthetic (beauty, ugliness), prudential (sensible, foolish), moral (good, wicked); there are different kinds of value-norm (personal, social, legal); and within all these, many values depend on the particular context (what's sauce for the goose is not always sauce for the gander).

Analytic moral philosophy has been concerned with the *general* logical properties of value terms, of whatever kind and in whatever context, and it is on these that we will be drawing in this session. But the differentiation *between* values of different kinds will also be important to us later on, in particular when we come to consider the various symptoms by which particular kinds of mental disorder are defined (i.e. psychopathology).

## R.M. Hare on descriptive and evaluative meaning

So, values are often implicit; and there are values of different kinds. None the less, if you managed the two lists, you will have recognized that there are some things about which, at least in a given context, people characteristically agree (like good eating apples), and other things about which they characteristically disagree (like good pictures). There are not two distinct categories here, of course, more a spectrum from agreement to disagreement.

We will see in this session that this spectrum is crucial to our understanding of the medical concepts. To get to that point, however, we need to look first at the second part of Exercise 6, at what lies behind agreement and/or disagreement over questions of value, what it is that we are agreeing or disagreeing about.

This was one of the questions studied by philosophers working in the linguistic analytical tradition. A particularly clear and well worked out approach to the question was developed by a former White's Professor of Moral Philosophy in Oxford, R.M. Hare (Figure 6.7), in his first book, *The Language of Morals* (1952). The

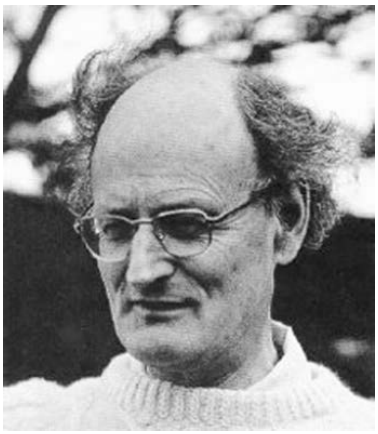

**Fig. 6.7** R.M. Hare

nub of Hare's argument on this point comes in his chapter 7, on 'Description and evaluation'. In the next exercise we read two key sections from this chapter.

**EXERCISE 7** (30 minutes)

Read sections 7.1 and 7.2 from:

Hare, R.M. (1952). Description and evaluation. Chapter 7, in *The Language of Morals*. Oxford: Oxford University Press, pp. 111–117

Link with Reading 6.5

In these sections Hare distinguishes descriptive and evaluative meanings. Make a note of the similarities he identifies between them; and of any differences.

- What meanings are normally carried by the value term 'good', according to Hare?
- What is the logical connection that he identifies between the two kinds of meaning in this case?

In these two sections Hare introduces the distinction between descriptive and evaluative meanings by way of examples of descriptive and evaluative expressions: e.g. 'This strawberry is sweet' (descriptive), 'This is a good strawberry' (evaluative).

### Evaluative expressions convey descriptive information

The first part of his argument can be summarized thus:

- These two kinds of expression, descriptive and evaluative, share many similarities. In particular, both may convey information.
- In the case of an evaluative expression, its information content is contained in the descriptive part of its meaning.
- This descriptive part of the meaning of an evaluative expression is carried by the criteria for the value judgement it expresses.

Thus, the evaluative expression 'This is a good strawberry' conveys the descriptive information 'This strawberry is sweet' because and to the extent that for most people sweetness is a criterion of goodness in strawberries.

### Evaluative expressions also commend

This, however, also points up a key *difference* between the two kinds of expression. The *primary* function of 'This strawberry is sweet' is to convey information; whereas 'This is a good strawberry' conveys information only *secondarily*. Moreover, 'This is a good strawberry' conveys the specific information 'This strawberry is sweet' *only* to the extent that sweetness happens to be a widely shared criterion of goodness in strawberries. This, then, is only a *contingent*, not a necessary, part of the meaning of 'good strawberry'. The primary meaning of 'good', according to Hare's account, is to *commend*. (See above, Chapter 5, introduction to logic, for the distinction between contingent and necessary.)

### Value judgements have descriptive criteria

We can sum up the connection between the descriptive and evaluative meanings of an evaluative expression, as defined by Hare, thus:

An evaluative *expression* (e.g. 'This is a good strawberry') expresses a value *judgement* (e.g. 'I commend this strawberry') the criteria for which are *descriptions* of the object of the evaluation (e.g. 'This strawberry is sweet').

### Back to Exercise 6

We now have all the conceptual tools we need to deal with the second part of Exercise 6.

**EXERCISE 8** (10 minutes)

Go back to Exercise 6 and think about the reasons you wrote down for agreeing or disagreeing on questions of value. In terms of Hare's analysis of the descriptive and evaluative meanings of evaluative expressions, what is it that you are agreeing or disagreeing about?

On Hare's account, agreement or disagreement over questions of value is likely to be agreement or disagreement over the *descriptive* criteria for the value judgements in question. When we make a value judgement, we do so by reference to criteria. But the criteria are not in themselves evaluative. They are, as we have seen, *descriptions of the things evaluated*. And when we agree or disagree over questions of value, we are agreeing or disagreeing over these descriptive criteria.

### Good apples and good pictures

How far is this account true of your own lists? It certainly seems to be true of apples and pictures. The descriptive criteria for goodness in (eating) apples are more or less consistent, at least given everyday situations: as we noted a moment ago, for someone buying apples from a grocer, say, a good (eating) apple is clean-skinned, sweet, and crisp. Even this assumes an everyday context, of course, hence the parenthetical 'eating'.

A good eating apple is not *necessarily* like this, of course. It is open to someone to prefer sharp rather than sweet apples, for example. A *cooking* apple should *not* be sweet. A *cider* apple should be rotten! But in a given context, it just is the case that most people more or less agree about the criteria for good eating apples. Whereas, by contrast, people tend to *disagree* about the criteria for good pictures—hospital committees have broken up over this question, and even the 'experts' often disagree violently!

### 'Good apple' describes; 'good picture' does not?

Thus far, then, we have seen that the criteria for the value judgements expressed by value terms are descriptive, that agreement on questions of value is (often) agreement on the descriptive

criteria for the value judgement in question, and that disagreement is (often) disagreement on the descriptive criteria.

These observations, however, have the consequence that the two kinds of value term (the agreement kind, as in 'good apple', and the disagreement kind, as in 'good picture') end up looking quite different in ordinary usage. We will see in a moment that this is a crucially important consequence for our understanding of the debate about mental illness. First, we will look at how Hare sets this out in a further extract from his chapter 'Description and evaluation'.

**EXERCISE 9** (20 minutes)

Read section 7.5 from:

Hare, R.M. (1952). Description and evaluation. Chapter 7 in *The Language of Morals*. Oxford: Oxford University Press, pp. 121–126

Link with Reading 6.6

Again think about your two lists. Hare notes that value terms expressing value judgements over which people *agree*, appear different from those expressing value judgements over which people *disagree*.

In what way do the two kinds of value term appear different, according to Hare?

Hare's point here is that where the descriptive criteria for a value judgement are widely agreed upon, *the descriptions in question can become attached by association to the meaning of the value term in question*. Hence, if the descriptive criteria are widely *agreed*, the corresponding value term comes to look like a *descriptive* term, whereas if the descriptive criteria are *not* widely agreed upon, the corresponding value term remains clearly *evaluative* in meaning.

Hare illustrates this with the difference between 'good egg' and 'good poem'. It is also shown clearly by our examples of 'good apple' and 'good picture'. As noted above, 'good (eating) apple' normally implies a clean-skinned, sweet, and crisp apple. Hence, although 'good apple' is a value term, it has come to look like a descriptive term (describing the apple to which it refers as 'clean-skinned, sweet, and crisp'). In everyday contexts this is taken for granted. If you are out shopping, as above, and the grocer gives you anything else in your pound of apples, you have grounds for complaint. You don't need to spell this out. Whereas with pictures, you do. The descriptive criteria for 'good picture' are not widely agreed, and there is no corresponding stable descriptive meaning that can become attached to 'good picture'.

### A brief overview of Hare's account

Before returning to the debate about mental illness (immediately below), we will briefly summarize Hare's observations about the properties of value terms in ordinary usage.

Value terms express (explicitly or implicitly) value judgements. A value judgement, Hare suggests, has two components:

- a *prescriptive*, action-guiding or commending component, and
- a *descriptive* component, representing the criteria adopted.

His emphasis on the prescriptive component has led to his account being called *prescriptivism*. Thus, the value term 'good apple' expresses the value judgement that the apple in question is good. The descriptive component of this is, in the case of eating apples, likely to include 'crisp, sweet, etc.'; but in addition to this descriptive meaning, the value judgement includes the prescriptive or action-guiding meaning 'eat it', or such like.

Hare also makes value-judgements *universalizable*. This is a property that marks out value judgements from other prescriptions, such as orders or instructions. The latter are one-offs. Value judgements are universalizable in the sense that if you judge something good, then you imply the same judgement of all (relevantly) similar things under (relevantly) similar conditions. This is important for ethics, but not here.

The exact extent to which descriptive meaning can become attached to a value term is a matter of philosophical dispute: 'non-descriptivists', such as Hare, consider that there will always remain a gap, even if very small, between description and evaluation; descriptivists such as another Oxford philosopher, G.J. Warnock, consider that the gap can close altogether. We return to this in the next session, when we re-examine the possibilities for a medical model of mental illness in the light of descriptivism. The point for now, though, is one on which both sides are agreed, namely that in cases such as 'good apple', a value term can come to look like a descriptive, or factual, term; while in cases such as 'good picture', its appearance remains clearly evaluative.

## Back to the debate about mental illness

The above observations, about the shifts in appearance of value terms in ordinary usage, have a clear *prima facie* relevance to the debate about 'mental illness'. The point of departure for this debate, as we saw in Chapter 2, was the overtly evaluative connotations of 'mental illness' compared with the factual or descriptive connotations of 'bodily illness'. And we have now seen that value terms, similarly, may sometimes have overtly evaluative connotations (as in 'good picture') and sometimes overtly descriptive (as in 'good apple').

### Good apple and good picture; bodily illness and mental illness

The correlation between the two kinds of case could be merely superficial of course. They could look similar but for quite different reasons. But it is also possible that 'illness', if a value term, varies in appearance between its uses in respect of mental and bodily conditions, much as 'good', as a value term varies in appearance between its uses in respect of pictures and apples. Before we consider this possibility, try one further exercise.

**EXERCISE 10** (10 minutes)

Write down two lists, one of increasingly painful situations (i.e. involving bodily pain), one of increasingly frightening or anxiety-producing situations. Now rate each of the situations on both lists according to whether they are welcome or unwelcome in their own right, i.e. something to take pleasure in or avoid in themselves, as distinct from being necessary for some other end.

If you are working in a group, make the value ratings individually for yourselves and then compare the results. If you are working on your own, make the ratings for yourself and then try to imagine someone who might take pleasure in either a painful or frightening situation, respectively, that you would avoid (or vice versa).

Most groups doing this exercise find that they agree on the pain list but not on the anxiety list. Correspondingly, for those working individually, most people find it is harder to think of people who would evaluate pain positively (for its own sake) than to think of people who would evaluate anxiety positively—some people enjoy horror films, some enjoy hang-gliding, some even bungee-jumping!

The key point is that there is considerable and legitimate variation between people in their evaluations of anxiety experiences; whereas for pain experiences, anything other than the mildest of brief pain is for nearly everyone at best a necessary evil. There *could* be differences of evaluation even of pain, but to envisage this we have to depart further and further from the everyday. There is nothing abnormal (non-everyday) about a good afternoon's hang-gliding; but what would we think of someone who enjoyed a good afternoon's pain? A masochist, or perhaps a saint?

This second exercise, then, has in effect added pain and anxiety to our initial two lists, of things that people respectively agree and disagree about evaluatively. But pain and anxiety are symptoms, respectively, of mental illness and bodily illness. Hence, if 'illness' is a value term, then simply because people tend to agree in their evaluations of pain but to disagree in their evaluations of anxiety, 'illness' used of bodily conditions (at least of pain, as in a 'heart attack', for example) will have relatively marked descriptive connotations compared with its use of mental conditions (at least of anxiety). If, then, illness is a value term, *for this reason alone, 'bodily illness' will have to have more marked descriptive connotations than 'mental illness'*.

### No special pleading

We have now got right back to the debate about 'mental illness' in Chapter 2, specifically to the more value-laden connotations of 'mental illness' compared with 'bodily illness'. We have come a long way round to get back to this starting point in order to make clear that whatever follows depends, not on anything special to medicine, still less to mental health, but only on, 1) a general logical property of value terms, taken together with, 2) an important characteristic of human beings.

1 The required logical property of value terms is the variation in the strength of their descriptive connotations with the degree of agreement on the descriptive criteria for the value judgements they express.

2 The required human characteristic is our widely varying evaluations of the aspects of human experience and behaviour with which psychiatry is concerned—anxiety, as we saw in Exercise 10, but also, more generally, affect, belief, desire, motivation, sexuality, and so forth. These, as areas of human experience and behaviour with which psychiatry is concerned, are also all areas of human experience and behaviour over which our values differ widely and legitimately.

That there is no special pleading involved here is shown diagrammatically in Figure 6.8. The top half of this figure shows the parallels between everyday evaluations and the value-ladenness or otherwise of the term 'illness' in different contexts: 'good' used of things such as apples carries mainly factual connotations, while used of pictures it carries evaluative connotations; correspondingly 'illness' used of things such as pain carries mainly factual connotations, while used of things such as anxiety it carries evaluative connotations. The bottom half of the figure indicates that (if 'illness' is a value term) *precisely the same explanation* operates in the case of 'illness' as in the case of 'good'. People differ in their evaluations of some things (e.g. pictures and anxiety) more than others (e.g. apples and pain). Where they agree, the value terms in question come to carry factual connotations by simple association with the factual criteria for the value judgements the terms in question express.

Differences of values, it is worth noting, are important. They reflect our very individuality as human beings. It is our individuality as human beings, then, which is expressed in the more value-laden nature of 'mental illness'.

## A watershed of understanding

The point we have now reached represents a watershed in our understanding of the medical concepts. For if the model represented in Figure 6.8 is right, it gives us an entirely different way of understanding the debate about 'mental illness'. Traditionally, 'bodily illness' was assumed to be a scientific term, if not value-free then capable of being so defined; and 'mental illness' had

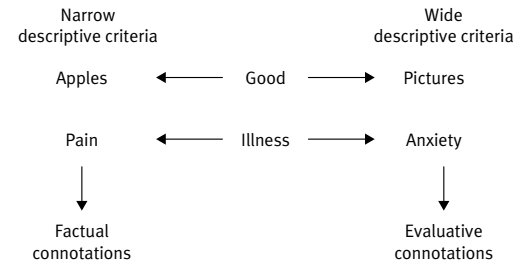


**Fig. 6.8** Diagrammatic representation of the parallels between 'good' and 'illness' as value terms.

then either to be *capable* of a corresponding value-free definition (as Kendell supposed, and, in a more complex argument, Boorse), or it had to be shown to be *incapable* of value-free definition, and hence not genuinely illness (as Szasz concluded).

The work of Hare, Urmson, and Warnock on the way value terms work in ordinary usage has now given us a picture that is in several respects the reverse of the traditional view. Instead of 'bodily illness' being value-free, it is now understood to have mainly factual connotations *just because it is a value term*. Like 'good apple', the criteria for the value judgement expressed by 'bodily illness' are relatively uncontentious, but it is no less of a value term for that. Moreover, on this scenario, the more marked evaluative connotations of 'mental illness' reflect *legitimate disagreement* over the criteria for the value judgements it expresses. Hence, attempting to force 'mental illness' into the mould of 'bodily illness', far from being a legitimate way of proceeding, could be positively dangerous. For it would only be possible to make 'mental illness' look like 'bodily illness' by suppressing the legitimate differences of values between people that are the basis of the more marked evaluative connotations of 'mental illness'.

'Mental illness', on this model, is more complicated and contentious than 'bodily illness'. In this respect the antipsychiatrists are right—'mental illness' is *not* just like 'bodily illness'; and so long as people have different values, it never will be. But 'mental illness' is not, thereby, invalid. On the contrary, 'mental illness', in being evaluatively more problematic, and hence more overtly value-laden, reveals the true nature of 'illness' as a value term, a nature that is hidden by the covertly evaluative concept of 'bodily illness'. We will examine the practical importance of this for bodily medicine as well as psychiatry later in this book (in Part IV). But it is a prime example of Austin's 'negative concept wearing the trousers'.

## 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. How far are people's values shared?
2. How did R.M. Hare characterize the relationship between the descriptive and evaluative elements in the meaning of an evaluative expression (e.g. 'this is a good strawberry')?
3. How may *evaluative* expressions come to appear as though they are purely *descriptive* expressions? Give one non-medical and one medical example.
4. How does this property of evaluative expressions (that they can come to look like descriptive expressions) help to explain the 'problem of mental illness'.
5. What is added by this session to the traditional medical-scientific model?

## Session 3 Adding illness to disease

The model of the medical concepts set out in the last session, although certainly more complete than the standard medical model (it offered a *clearer* view, as Wittgenstein would have said), none the less remains in an important respect *in*complete. One way to see this is in terms of the map, or logical geography, of mental disorders introduced in Chapter 2.

### Medical and other values

If you refer back to this map, you will recall that it showed a variety of different forms of mental illness merging with bodily illness on one side and moral categories on the other. M*ere* fact (or psychopathology) and *mere* value, are not sufficient to explain the feature of the map, therefore. What is also required is some means of differentiating *medical* value from other *kinds* of value: illness from immorality, disease from delinquency, ugliness, and so forth.

#### There is more to mental illness than (negative) value simpliciter

This further differentiation is important in principle. It is also important in practice: many of the trickiest conceptual problems in mental health practice arise not from differences over values *per se*, as from difficulties about the particular *kind* of value involved. 'Mad or bad?' is the standard form of this problem in forensic psychiatry. But what about more everyday cases?

**EXERCISE 11** (30 minutes)

Go back to the cases we examined in the first session in Chapter 2. Are the problems considered there sufficiently characterized as problems about people's values? In Mr AB's case, for example, was there significant disagreement about whether or not he was in a *bad* condition? If not, what was the disagreement really about?

Mr AB's case, as a case of involuntary psychiatric treatment, is an example of the non-forensic equivalent of 'mad or bad?'. There is unlikely to have been disagreement about whether he was in a bad condition as such. As we will see later (when we retain to Mr AB in Part IV), there *is* disagreement about whether he should be treated under the Mental Health Act (roughly a 50:50 split). But the disagreement here was about whether his bad condition is a bad condition of the kind that is appropriately regarded as mental *illness* (and hence appropriately treated by doctors under the Mental Health Act). The issue, then, was in effect, 'mad or, just, *sad*?'.

#### Little help from moral philosophy

Surprisingly little work has been done by philosophers on the differentiation between different kinds of value—moral, aesthetic, prudential, medical, etc. Most moral theory is concerned with the properties of value terms in general. The differentia, though, are critical for mental health. The demarcation problem (which was Boorse's problem) consists in just this. Ugliness, wickedness,

illness, etc., are all negative value terms. Recognizing this has important implications. But the differentiation between them as different *kinds* of negative value term (mad or bad, mad or sad, etc.) is central to the conceptual problems presented by mental health.

### More help from the medical model?

In this session and the next we start to fill out our picture of the conceptual structure of medicine by sketching in the elements of an account of the particular kind of negative value judgement expressed by illness. This will in effect pick up on the line of argument we started to explore in Chapter 4 in relation to Boorse's work on the distinction between illness and disease. Boorse, you will recall, was concerned with the demarcation problem, namely with where the boundary between medicine and morals should be drawn. He tackled this by distinguishing between illness (broadly, what the patient experiences) and disease (broadly, scientific medical knowledge of the disturbances of bodily structure and functioning that cause illness), and he argued that we could distinguish medical from moral values by reference to the latter. However, Boorse's approach to the demarcation problem, we suggested, failed to the extent that it depended on disease being defined value-free while his own *use* of the concept remained value laden.

In the remainder of this session we consider two ways of attempting to preserve a traditional medical model, i.e. a model in which (as in Boorse's theory) values have a place but remain secondary to facts. The failure of both these approaches will reinforce the essential (and indeed primary) importance of values, and of the particular kind of value expressed by illness, in the conceptual structure of medicine and psychiatry. This in turn will lead us, in the final session of the chapter, to a positive characterization of the concept of illness as a particular kind of disturbance of action or of agency. What all this will amount to, as we anticipated in the first session of this chapter, is an enlarged or more complete picture of the conceptual structure of medicine and psychiatry, thus providing a framework for much of the material we will be covering in the rest of the book.

## A medical model by logical reduction of illness to disease?

The two ways of attempting to preserve a medical model while retaining a place for values in the medical concepts, are both reductive: one involves a *logical* reduction, the other a *causal* reduction.

The logical reductive route is via moral descriptivism. This is the theory, advanced by authors such as the Oxford philosophers Phillippa Foot and G.J. Warnock, that at least some value judgements are *entailed* by certain matters of fact. This is a strong claim. It means that, given certain matters of fact, particular value judgements follow by *definition*. (We covered entailment in Chapter 3.)

**EXERCISE 12** (45 minutes)

Read the two extracts from:

Foot, P. (1967). Moral beliefs. Chapter VI in Foot, P. (ed) *Theories of Ethics*. Oxford: Oxford University Press, pp. 83–84, 85–86

Link with Reading 6.7

Refer back to the section of the Introduction to Logic concerned with the difference between ordinary and strict implication. In the light of this, what do you think of Foot's arguments in 'Moral beliefs'? What is the relevance for the medical model of her view of the logical relationship (the relationship of meaning) between facts and values?

Foot's argument is to the effect that there are cases in which to reject a particular evaluation (of good or bad) seems not merely to be perverse but to show a failure of understanding of the very meaning of good and bad. G.J. Warnock develops a similar argument in his *The Object of Morality* (1971). If these (descriptivist) authors are right, cases of the kind they discuss would be the equivalent of the example of strict implication in the *Introduction to Logic*, 'bitch is a female dog'. Hence values, in cases of this kind, would be reducible (logically) to facts. An expression of value correspondingly could be restated without loss of meaning in terms only of statements of fact.

### Can we have our cake and eat it?

Moral descriptivism, making values (sometimes) reducible to matters of fact alone, is a highly attractive theory for the traditional medical model. For it effectively allows us to have our cake and eat it, evaluatively speaking. On the one hand, if the *medical* value terms (disease, dysfunction, and so on) can be reduced to purely factual terms, then this (logical) reduction would satisfy Boorse's requirement (in Chapter 4) for a value-free science of health. On the other hand, though, because these facts entail the relevant negative value judgements, the medical value terms can continue to be used (as Boorse himself continues to use them, remember) with evaluative connotations.

Hare, however, whose work we drew on earlier, offers some powerful arguments against the reduction of values to facts, even in the *prima facie* plausible cases offered by Warnock and Foot.

**EXERCISE 13** (30 minutes)

Read the two extracts from:

Hare, R.M. (1972) Descriptivism, ch 5 in *Essays on the Moral Concepts*. London: The Macmillan Press (Extracts, pp. 70–73, 97–100.)

Link with Reading 6.8

These two extracts are both short. But think carefully about them, again with the ideas introduced in Chapter 3 (introduction to logic) in mind, before going on. Hare mounts two main arguments against descriptivism, one in each extract. What are they? Do you agree with him?

In the first extract (pp. 70–73), Hare suggests that the plausibility of descriptivism consists in the fact that the descriptive terms in the cases discussed by Foot (and Warnock) are so widely, perhaps universally, adopted as criteria for the value judgements in question. But this is a contingent fact about human beings, a fact of psychology, not a necessary requirement of logic. We can see this by applying what Mary Warnock, in *Ethics Since 1900* (1978) calls the test of non-contradiction: it would *not* be self-contradictory, in the case of ethics, to acknowledge the descriptions but deny the evaluation; while it really *would* be self-contradictory to acknowledge that an animal is a bitch but deny that it is a female dog. But as Hare points out in this extract the examples given by descriptivists, such as Warnock (G.J.) and Foot, do not pass this test. The force of descriptivism is, rather, contingent. The force of descriptivism derives from the fact, which is a fact of psychology not logic, that over some things (things of the kind on which descriptivists draw) our values are largely shared. Hare, in this extract, anticipating later descriptivists on the medical concepts (like Kendell, in Chapter 2), gives by way of example the biological needs of survival and reproduction ('procreation', p. 72). There is a strong compulsion to say of something that contributes to our survival and/or reproductive potential, that (other things being equal) it is a good thing. But this trades on the merely contingent fact of our psychology that over situations of the kind in question our values are very widely shared. It would be psychologically odd, to the point perhaps of being disingenuous, to admit the facts but deny the values in such cases. But it would not be self-contradictory.

Hare's argument in the second extract (pp. 97–100) is more complex but amounts to the same end result. The plausibility of the descriptivist's case, he argues, consists in the fact that the supposed descriptions are not, actually, value free. 'Harm' appears to be a matter of fact, in the sense that it only makes sense to call certain things or states of affairs harmful. But this is because 'harm' is connected logically to 'interests', which in turn is connected logically to 'desiring' and 'wanting', neither of which can be defined value-free. So 'harm', despite its factual or descriptive appearance, itself contains a hidden element of evaluative meaning, a hidden evaluative premiss. (For the relevance of this point to philosophical work on the concepts of function and 'dysfunction', see Session 4, below, and Fulford, 2000.)

### The debate about mental illness and the 'is-ought' debate

In both cases, then, Hare argues, despite appearances, values cannot be reduced to facts; or, equivalently, no set of descriptions of a situation will in themselves entail a value judgement.

In taking this position, Hare is the latest in a long line of philosophers who have argued that there is an unbridgeable logical gap between description and evaluation. This 'is-ought' gap, as it is sometimes called, was first explicitly pointed out by David Hume (in his *Treatise of Human Nature*, (1739/40) III, I, i, final paragraph). But the debate between reductionists (like Warnock and Foot) and non-reductionists (like Hume and Hare) has produced a large literature on the logical links between description and evaluation.

Most philosophers nowadays accept the Hume/Hare line. They argue, however, that the gap between fact and value is not very important in practice. Be that as it may, in mental health at least, we will find that this is far from the case. Disentangling description from evaluation, and recognizing values for what they are, turns out to be crucially important, for example in relation to the abuse of psychiatry (see later).

But there is, anyway, a decisive argument against the *general* effectiveness of descriptivism as a device for preserving the medical model, at least in mental health. In so far as it is plausible at all, descriptivism depends on (more or less universal) agreement in the criteria for a value judgement. This is what made Foot's (and Warnock's) examples persuasive—everyone, surely, agrees that it would be absurd to claim that clasping and unclasping your hands, etc. (as in Foot's example) is a good thing. Agreement on factual criteria of this kind, as we saw in Session 2, is characteristic of 'bodily illness' (or at any rate 'disease'); however, as we also saw in that session, mental illness differs from bodily illness *just in that the criteria for the value judgement expressed by mental illness are not widely agreed upon*.

In relation to mental illness, then, the conditions for a descriptivist reduction of values to facts are not satisfied. Hence, even if the descriptivist's reduction were valid in principle, it would not work when (from the perspective of the traditional medical model) it is most needed, in mental health.

## A medical model by causal reduction of illness to disease?

Although less radical than the logical reduction offered by moral descriptivism, the causal reduction of illness to disease is by far the more familiar, at least among doctors.

**EXERCISE 14** (10 minutes)

Spend a few minutes thinking about what happens when you go to see your doctor feeling unwell; for example, unusually tired, or with a sore throat. How does your doctor deal with this, typically? What does he or she do? What kind of thing does he or she say to you by way of a diagnostic conclusion?

In terms of the demarcation problem, this scenario amounts to going to your doctor in a bad condition and wanting to know 'if there is anything (medically) wrong?'. The doctor asks a few questions, does a 'physical' examination, may take a few tests; and then comes up with a diagnosis. 'Yes, you are anaemic' or 'you have a "strep" sore throat', etc.; or, 'No, there's nothing wrong. You are just tired'/'have been overworking', etc. The line of reasoning implied in this process is that if a known disease (anaemia, streptococcal infection) is causing your bad condition, then your condition is an illness; if not, it is not. In other words, if the *cause* of your bad condition (e.g. feeling tired) is a *disease* (e.g. anaemia),

then your bad condition is an *illness*; if not, it is not (i.e. No, there's nothing (medically) wrong. You're just tired).

### Diagnosis by causes

We return to the diagnostic process in detail in Parts III and IV. The point for now is that, consistently with the medical model, diagnosis of this kind (by reference to causes) in effect seeks to differentiate between medical and non-medical negatively evaluated conditions, by tracing the *cause* of a symptom to some underlying bodily abnormality (such as low blood haemoglobin or the presence of specific bacteria in the throat).

This is a common line of reasoning in other areas of medicine when issues of responsibility come up. In forensic psychiatry, for example, the courts are always impressed by such 'physical' findings as abnormal EEG's (patterns of electrical activity in the brain); this is taken to imply (1) that the person concerned 'could not help' what he or she did, and (2) that a 'physical' finding means that they are ill (again, hence not responsible).

### Causes and responsibility

The model of mind and brain implicit in diagnosis of this kind, is also one that is widespread in the biological sciences, and indeed in everyday thinking.

**EXERCISE 15** (10 minutes)

Think about the issues raised by the quest for a gene for homosexuality. There has been much published on this issue. You might want to look up on the Web a summary of one such book: *The Sexual Brain* by Simon LeVay (MIT, 1994), which MIT describes as follows: 'Written with clarity, directness, and humor, *The Sexual Brain* examines the biological roots of human sexual behavior. It puts forward the compelling case that the diversity of human sexual feelings and behavior can best be understood in terms of the development, structure, and function of the brain circuits that produce them.'

This book was reviewed by John Diamond in the *Sunday Times* (15 July 1993) in a short review called 'Born to be Gay?', which we discuss below. If you have access to this review you can use it to think about the following issues: what model of the relationship between mind and brain is implied here? What answer to the problem of differentiating medicine from morals (the Boorse demarcation problem), does this suggest? If you do not have access to the review, think about these questions in general.

Work on the brain 'abnormalities' underpinning homosexuality suggests the same model of mind and brain as 'diagnosis by causes'. The abnormality, described in Simon LeVay's book and summarized in the *Sunday Times* review by John Diamond, in the anterior hypothalamus, is taken, somehow, to show that being gay is not freely chosen but determined by the individual's brain. At the top of the fourth column of the *Sunday Times* review this is made explicit. LeVay, the researcher, is said to claim that this finding '. . . proves that gays are . . . no more able to choose their sexual orientation than blacks . . . are able to pick a skin colour'. Well, perhaps so, but if this is the case, then, (1) the same must be true of heterosexuals, and (2) there is nothing in this to make the brain abnormality (in the statistical sense) into a disease. Yet, as we have just seen, these are both corollaries that are regularly drawn, albeit usually implicitly, in medical and legal contexts.

It is important to add that 'diagnosis by causes' is legitimate up to a point. It is legitimate to the extent that it depends on the relevant causal conditions *already being defined as diseases*. By the same token, though, it is wholly illegitimate to extend it to areas where this is not the case, where the point at issue is whether the condition in question is a disease at all.

### Two kinds of differential diagnosis

To see this, it is helpful to recognize that there are, really, two different types of diagnosis:

- *Type 1* seeks to allocate a diseased condition to a particular category *within* an established classification of diseases (we can call this 'disease diagnosis').
- *Type 2* seeks to determine whether a condition is properly included in a classification of diseases at all (we can call this 'illness diagnosis').

In medical contexts, these two kinds of differential diagnosis are often conflated. The situation is complicated. But one way to see that these really are distinct types of diagnosis, albeit often run together, is by considering conditions for which the causes are not yet known. The diagnosis of migraine, for example, depends on the features of the condition itself (one-sided headache, etc.). Various risk factors for migraine are recognized (stress, chocolate, etc.) but its underlying causes, at a (medically) acceptable physiological level at least, are not understood. None the less, migraine is firmly within the established classification of diseases. Hence, it cannot be in the classification, it cannot be 'on the list', by virtue of our knowledge of any underlying causal process.

We return in Session 4 of this chapter to just what it is about 'symptomatically defined' conditions such as migraine that gets them on the list of diseases. This is important for psychiatry, most mental disorders being, like most neurological disorders, defined symptomatically. But the key point for now is that causation, although one basis for differential diagnosis of type 1 (disease diagnosis) cannot be the basis for differential diagnosis of type 2 (illness diagnosis).

### Some practical sequelae

The practical problems caused by conflating these two types of diagnosis are particularly prominent in psychological medicine but also occur in bodily medicine. There can be few doctors who believe that we have already identified all existing diseases, still less that new diseases will not continue to arise. Yet all too commonly, a patient who feels *ill* is told there is 'nothing medically wrong' simply because their condition cannot be allocated to a known *disease* (conflating the two types of diagnosis).

This is a common experience in all areas of medicine. But in forensic psychiatry, as we saw above, there is a strong tendency to equate the *mere* discovery of a cause with the presence of disease. Yet health, no less than disease, must be caused. So at the very least, it is a *disease*-as-cause that is relevant to the attribution of responsibility in law.

## Illness defines disease

The essence of the objection of principle to the standard diagnostic process amounts to the idea that it puts the cart before the horse. Far from diseases-as-causes marking out negatively evaluated conditions as illnesses, it is illnesses (patients' negatively evaluated experiences) that mark out causal conditions *as* diseases. This is shown schematically in the diagram. The direction of causation (from disease to illness) is the opposite of the flow of meaning (from illness to disease).

### Asymptomatic diseases

Once a bodily state has been identified as a cause of illness, however, and hence as a disease, it can then be used diagnostically; and this is what legitimizes (up to a point) the standard diagnostic process. This is true, in particular, of asymptomatic diseases, i.e. where a person is said to have a disease even when they are not aware of anything wrong. Causes, as Ayer (1976) put it, are 'connections of tendency'. Hence discovering a 'shadow on the lung', say, picked up on a routine chest X-ray, may lead to the person concerned legitimately being said to have a disease, because the condition in their lungs is one that has a causal 'connection of tendency' with people becoming ill. But what legitimizes this, is that the causal connection, between conditions of this kind in lungs and people being ill, has already been identified.

It is, then, even in the case of asymptomatic diseases, the experience of illness by which, ultimately, a bodily condition is marked out *as* a disease. But the enormous extent to which such bodily conditions have been marked out as causes of illness, especially in the last hundred years, has led to the illusion that diagnosis *as a whole* is nothing more than recognizing already identified diseases. This can indeed give us short cuts to diagnosis (a blood test, or X-ray, etc.). But the short cuts depend on a long (logical) route having already been mapped out.

So far as causal reduction is concerned, then, far from preserving a medical model answer to the demarcation problem, it shows that the medical model actually depends on a prior, and essentially non-medical model, answer. The 'disease' answer depends on a prior 'illness' answer. It is illness, not disease, which drives the logic of diagnosis, whatever logical short cuts are available once the prior process of discovery of diseases-as-causes has gone through.

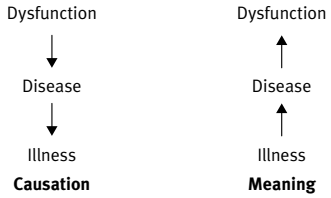


**Fig. 6.9** The different directions of the causal and logical connections between the experience of illness and dysfunctional states as diseases (based on chapter 4 of Fulford's *Moral Theory and Medical Practice*, 1989).

### So what is illness?

The failure of causal reduction reinforces the need for an account of illness which is not dependent on that of disease. As we have seen, part of what is involved here is a negative value judgement. But this is not sufficient. In the next session, we outline a more complete account of the concept of illness, and how it gives us a clearer picture of the conceptual structure of medicine.

## 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. Is adding 'values to facts' sufficient for a more complete picture of the conceptual structure of medicine? If not, why not?
2. What philosophical account of the relationship between descriptive and evaluative meaning might be used to reduce the evaluative element in the meanings of the medical concepts to a descriptive element?
3. What is the difference between the causal and logical relationship between illness and disease?
4. Does disease define illness, or illness disease? If the latter, how do we account for asymptomatic diseases?
5. What does a non-descriptivist account of the relationship between illness and disease add to the traditional medical model?

## Session 4 Adding action to function

If illness is not defined by disease, as the medical model requires, how is it to be characterized? How, generally, do we come to think of an experience *as* an illness?

This question has been studied as much by sociologists as by philosophers. It is indeed one of those questions that admits equally of empirical and of conceptual answers. In reviewing some of these answers in this session, we will be adding a further element to our more complete picture of the conceptual structure of medicine; a picture around which, as we will suggest in the conclusions to this chapter, many of the topics at the interface between philosophy and mental health can be assembled.

## A logical geography of illness

### The experience of illness

Before we get to this more complete picture, however, we need to look at the features of our everyday use of the concept of illness. Philosophically, this will involve a further exercise in philosophical fieldwork. So, rather than starting with a reading, we will begin with a practical exercise.

**EXERCISE 16** (60 minutes)

This exercise comes in two parts, a practical exercise and then a reading. They should take about 30 minutes each. Please do both!

1. Think about moving and not moving. Move your hand, to put down a book, say. Now rest your hand on the table. Or, stand up and walk around the room; then, sit still in your chair. Now imagine that you go to perform any of these actions (including those that involve keeping still) and find that you can't. Would you think there is something wrong with you? Would you think you were ill? Write down (a) as many aspects of the experience of failing to move or keep still that you can think of which, for you, would be likely to increase and/or decrease the likelihood of thinking that you are ill; and (b) any alternative accounts of your experience that you can think of, i.e. ways in which you might think of it other than as something (medically) wrong with you.
2. Now read the four brief extracts from:

   Locker, D. (1981).The construction of illness. Chapter 5 in *Symptoms and Illness*. London: Tavistock Publications, pp. 95–96, 96–97, 100, 101

Link with Reading 6.9

David Locker did important empirical work on the features of experiences by which they are marked out as illnesses. As you read the extract, particularly the way the interviewees talked about their experiences, see how far this connects with your own responses in the first part of the exercise.

The point of this exercise is to start us thinking about the features of an experience that identify it as an experience of *illness*. As we should expect (from the fact that we are in general better at using concepts than at defining them, see Chapter 4), this is a surprisingly difficult thing to do. As David Locker notes elsewhere (in the introduction to his book), even sociologists have largely taken for granted that the meaning of 'illness' is self-evident.

This extract illustrates a number of important points. First, illness is related to but not the same as disease, or underlying disorder. This comes out also in cross-cultural work (see especially Fabrega's work in the Reading Guide). Second, as we should expect, elements of the concept of disease are very much mixed up with the experience of illness (e.g. p. 96 of this extract, Locker notes that illness, as in the interview at the bottom of the preceding p. 95, is perceived as '. . . the product of some underlying disorder'). Third, though, the experience of illness has a number of important features in its own right. We can summarize these features thus:

- *Feature 1—negative evaluation*: the experience (of failing to move or keep still) is *negatively* evaluated. We should expect this from everything we have done so far on the concepts of illness and disease; and this is a theme that runs right through Locker's interviews. They are all about 'problems', 'disorders', and so on.
- *Feature 2—intensity and duration*: the experience must have a certain *intensity and duration*. Again, this is implicit in Locker's interviews and is likely to have been clear from your own responses to part 1 of Exercise 16. Thus, in the case of movement/keeping still, a very brief difficulty in initiating action, one immediately rectified, is not experienced as illness. You might think that you had been clumsy, perhaps, or inattentive. These would be reasonable alternative accounts of such experiences. But a failure to move or to keep still has to be of a certain intensity and/or duration before you start thinking there is something wrong, before you 'call the doctor'.
- *Feature 3—not 'done or happens to' me:* the experience must not be obviously due to some *obstruction*. If I fail to walk around the room because someone trips me up, the experience is not of illness. In Locker's interviews, this is implicit at several points, and fully explicit, for example, at the bottom of p. 101, where a mother describes her daughter having hurt her leg: 'that's not an illness. . . .', she says.

  In general, anything that we experience as being *done or as happening to* us is not, in this experiential sense, illness. Things being done or happening *to* me, to revert to part 1 of the exercise, are further alternative explanations for a failure to move or to keep still, even where such failures are intense (I fall heavily) or sustained (I keep falling over because people keep tripping me up).
- *Feature 4—not 'done by' me:* the experience must not be of me *doing something*. If I simply keep my hand still, or sit firmly in my chair, that is not paralysis. It is, simply, me keeping still. So long as a movement, or keeping still, remains under my control it is not experienced as illness.

Thus, in Locker's study, the experience of illness is sharply distinct from what he calls 'motivated behaviour'. The lady referred to illustrates this point very well. She could not do what she would ordinarily have done (go to her son's school concert): she felt so sick, she had to lie down. There is a sense, then, in which her behaviour (lying down) was something she did; but as Locker puts it, it was, really, imposed on her by her subjective state. (Hence, it is also not something that is done or happens to her, in the sense of feature 3 above, because there is no external agent.)

## Illness and failures of 'ordinary doing'

In chapter 7 of his *Moral Theory and Medical Practice*, Fulford (1989) argues that these features of the experience of illness can

be drawn together if we think of the experience of illness as involving, at least in the first instance, a failure of a particular kind of action.

**EXERCISE 17** (45 minutes)

Read the extract from chapter 7 in:

Fulford, K.W.M. (1989). Illness and action. In *Moral Theory and Medical Practice*. Cambridge: Cambridge University Press, pp. 115–119

Link with Reading 6.10

Concentrate for the moment on the analysis offered of 'illness'. There is a good deal elsewhere in the chapter about the relationship between 'function' and 'action', and we will return to this later in this session. But what do you make of the analysis offered of illness? In particular, note:

1. how Fulford derives the features of the experience of illness from the notion of 'action failure', and
2. of the many different kinds of action of which people are capable, the particular kind of action (failure) that he argues is relevant to the experience of illness.

In this extract, Fulford argues that the primary experience of illness (at least as instantiated by movement and/or keeping still), can be analysed as a failure of 'ordinary doing' in the perceived absence of obstruction and/or opposition. The term 'ordinary doing' is borrowed from Austin. It means those things that are done, not reflexly, but usually without thinking too hard about them. As illustrated in the extract, then, ordinary doings, in Austin's sense, are actions we normally just get on and do, but which, if we reflect on them, are none the less seen to be intentional.

The details of this part of Fulford's analysis of the medical concepts are complicated, but the main points of his derivation of the features of illness can be summarized thus:

- Feature 1 (negative evaluation) follows directly from the fact that actions involve intentions that entail positive evaluations (hence *failures* of action entail the *negative* evaluation entailed by 'illness'). Spelling this out a bit, to act intentionally is to act for a reason (or intentionally, on purpose); this implies that your intention, your object, is one which, for you, is desired, wanted or in some other way positively evaluated; hence the *failure* of this is, correspondingly, a *negatively* evaluated experience.
- Feature 2 (intensity and duration) derives from the way that ordinary, everyday actions are defined by reference to norms or expectations of our capacities. We expect to be a bit slow or clumsy. The norms involved here are individual as well as group specific—an athlete failing to run a 4-minute mile might think there was something wrong with him, whereas you or I, perhaps, would not. Illness experiences thus fall outside the range of normal expectations as set by individual and collective norms.
- Feature 3 (not done or happens to); this too derives from ordinary actions. Our experience of performing actions is derived in contrast to being pushed or pulled by the world. Hence being obstructed is experienced as action being prevented rather than as a *failure* of action.
- Feature 4 (not done by). That illness is not something we do, is simply the action-failure theory made explicit.

Illness as a kind of 'action failure' corresponds with the idea that illness entails incapacity—the inability, rather than refusal, to do things. Talcott Parsons, in his classical sociological studies of deviance (Parsons, 1951), made this a central feature of illness: illness is something for which we are not responsible; it is therefore an excuse. (We noted this as a feature of the conceptual map of psychiatry in Chapter 2.)

### The phenomenology of illness

Our understanding of the experience of illness is a good example of the way in which the explicit analyses offered, typically, by Anglo-American philosophy, are complemented by the more intuitive appreciation that we get from Continental Philosophy (see Chapter 4). This is well illustrated by the work of the American philosopher and phenomenologist Kay Toombs.

**EXERCISE 18** (45 minutes)

Read the four extracts from:

Toombs, K. (1993). The body. Chapter 3 in *The Meaning of Illness: a phenomenological account of the different perspectives of physician and patient*. Dordrecht, The Netherlands: Kluwer Academic, pp. 62–63, 63, 66–67, and 70–71

Link with Reading 6.11

Make notes as you go along on the features of the experience of illness as Kay Toombs draws them out through her work in phenomenological description. In particular, note how she uses descriptions of the lived body to illuminate the experience of illness.

In this chapter, Kay Toombs is concerned with the experience of bodily illness. She starts with an account of the lived body as this has been developed in the phenomenological literature. Essentially, the lived body is our prereflective mode of being, in particular our continuing (and normally taken for granted) potential for action, which arises from our open relationship with the world. Hence, the essential characteristic of the experience of illness is a closing down or diminution of this open relationship, with a consequent restriction of our potential for action.

Kay Toombs introduces this idea initially on pp. 62–63. A particularly clear example is given on p. 67 in relation to our

experience of space (this being a component of our relationship with the world upon which our taken-for-granted potential for action critically depends, but of which we are normally unaware, i.e. it is prereflective).

There are obvious parallels between this phenomenological account of illness and that derived above linguistic analytically; the phenomenological 'taken for granted potential for action' is very close to Austin's 'ordinary doing'; the phenomenological 'restriction of action' is very close to Fulford's 'failure of ordinary doing'. The two kinds of account, then, are indeed not in conflict but complementary.

## Two objections

The importance of 'action failure' (failure of 'ordinary doing' in the perceived absence of obstruction and/or opposition) as being at least a feature of the experience of illness, is thus supported both by empirical evidence (your own practical experience; and the social scientific literature) and by philosophical analysis (linguistic and phenomenological).

At this point, however, two objections to an 'action failure' account of the experience of illness may have occurred to you: (1) that 'action failure' may seem little different from the 'failure of function' (or 'incapacity') emphasized by writers such as Boorse—so are we back with the same disease model by another name?, and (2) that this account may work for movement (tics, chorea, etc.) and keeping still (paralysis), but most illness experiences involve sensations (fear, pain, dizziness, etc.). Indeed in bodily medicine, sensations (fear, pain, dizziness, etc.) and perceptions (blindness, etc.) are more common than disturbances of movement; and in psychiatry, illness experiences involve a whole range of other phenomena—emotions, desires, motivations, etc. So, the question is, is an action-failure account of the experience of illness generalizable?

### Objection 1: action and function

Taking these two objections in turn will fill out the action failure account of illness. The first objection, then, is that there may seem little difference between 'action failure' and 'failure of function'. This is covered in detail in Fulford (1989, chapter 7). We read a section from that chapter in Exercise 17 above and will be looking at a further brief extract below (Exercise 20). First, though, a good way to get clear about this is with a further practical exercise.

**EXERCISE 19** (10 minutes)

Carry out any of the simple actions you tried at the start of this session; for example, putting down a book. Now, under what circumstances would you naturally think of this as your hand/arm functioning rather than as an action of yours? Write down one or more suggestions before going on.

This exercise brings out a number of points (covered in Fulford, 1989, chapter 7) about the relationship between function and action. It shows, in particular, that they are not sharply distinct, that, indeed, for some things we do they are two sides of the same coin. Which side of the coin we use then depends on the context. Putting down a book—one of Austin's 'ordinary doings'—is an *action* in the context of human beings relating to each other as agents. But once we focus on the parts or systems of which people are composed (arms, hands, etc.), it becomes natural to talk of *functions*. This would be true, for example, of a neurologist carrying out an examination of someone's arm.

### Failure of action and failure of function

So, people (as agents) perform actions; bits and parts of people function. And this difference maps neatly on to the distinction between the patient's experience of illness and the doctor's knowledge of disease. This is spelled out in the next reading.

**EXERCISE 20** (10 minutes)

Read the extract from:

Fulford, K.W.M. (1989). Illness and action. Chapter 7 in *Moral Theory and Medical Practice*. Cambridge: Cambridge University Press, pp. 126–127

Link with Reading 6.12

- Note the way in which, on this account, action failure is the natural way to analyse illness, where failure of function is the natural way to analyse disease.

As the reading in the above exercise indicates, differences in the uses of 'action' and 'function' correspond with differences in the uses of 'illness' and 'disease'. The most important of these is that actions are typically predicated of people while functions are typically predicated of organs, limbs, systems, or other parts of people. This is also true of illness and disease. Insofar as these are distinct, it is people who fall ill, the parts of people (livers, cardiovascular systems, etc.) which become diseased.

There is a spectrum here, of course, in which, as Fulford notes, ordinary doings, relatively simple actions, fall about mid-way. The more complex an activity, the more voluntary, the more it is something that a *person* does, then the stronger is the use of 'action'; conversely, the simpler an activity, the less voluntary, the more it is something that a *part* of a person does (a nerve, a blood cell, etc.), then the stronger becomes the use of 'function'. And the kinds of action-failure by which illness is characterized (i.e. the 'ordinary doings') fall in that part of the spectrum where action and function are equivocal. And this directly corresponds with the equivocal nature of illness and disease.

As Figure 6.10 indicates, then, the direct correspondence of these two equivocations (the equivocation between function and action corresponding with that between dysfunction and illness), strongly supports the wider claim that where dysfunction, and hence disease, are naturally analysed in terms of 'functional doing', the experience of illness is naturally analysed in terms of

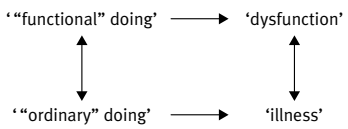


**Fig. 6.10** The relationship between action and function, illness and dysfunction. Source: Fulford, K.W.M. (1989). Illness and action. In *Moral Theory and Medical Practice*. Cambridge: Cambridge University Press, p. 127.

failure of the particular kind of action that Fulford, following Austin, characterizes as 'ordinary doing'.

### Objection 2: movement and pain

So much for objection 1. What about objection 2, that illness experiences often involve sensations such as pain, rather than movement, or indeed emotions, beliefs, etc. as in mental health, and hence are not so obviously linked with action failure as this account might suggest. The question, then, is how far is this account generalizable from movement-as-illness to other kinds of illness experience?

**EXERCISE 21** (30 minutes)

Some authors (e.g. including Boorse, 1975) have sought to define illness in terms of either incapacity or pain. Do we need another kind of illness? Or is 'action failure' generalizable to things other than movement? Try running through the four features of illnesses (noted above) for (1) pain, and (2) memory. Are these assimilable to action-failure?

Like movements, not all pains are experienced as illness, and, at a first level at least, pain-*as*-illness appears to be very similar to movement-*as*-illness.

Thus, pain-as-illness is *negatively evaluated*. However, negatively evaluated experiences of pain are not necessarily experienced as illness (pain, although usually negatively evaluated, is not *necessarily* so; for an excellent discussion of this, see Hare [1964]1972). Hence, even granted that an illness experience (of pain) is a negatively evaluated experience of pain, there must be other features of the experience as well. These features, as for movement-as-illness, include a certain *intensity and duration* (a very brief, mild pain is unlikely to be experienced as illness); moreover, and again analogously with movement-as-illness, pain-as-illness is distinguishable both from '*done or happens to*' experiences, i.e. from pain that is manifestly either inflicted by others or due to some other external cause, and, pain that is being '*done by*' someone, i.e. is self-inflicted. Thus, pain-as-illness is distinct both from my hand held in the flame by others, and from me holding it there.

### Movement, sensations, and the machinery of action

There are thus *prima facie* parallels between pain-as-illness and movement-as-illness. But this still leaves the basic objection, that pain, unlike movement, just does not 'look like' an action. So, if the experience of illness is, somehow, derived from action-failure (of a particular, 'ordinary doing', kind), how does pain become experienced as a symptom? The next exercise focuses on this question.

**EXERCISE 22** (15 minutes)

This is a two-stage exercise.

1. Start by thinking about whether there is any sense in which pain is involved with action. There is a crucial step here, crucial to our understanding of the concept of mental illness.

Link with Reading 6.13

2. After thinking about this for yourself, read the further extract from:

   Fulford, K.W.M. (1989). Illness and action. Chapter 7 in *Moral Theory and Medical Practice*. Cambridge: Cambridge University Press, pp. 135–136

As this reading brings out, there is clearly a sense in which movement and pain are quite different *viz-à-viz* action. Movement is executive. There is more to action than movement, as we saw a moment ago (there is intention, motivation, perception, etc.). But without movement, actions could not be performed. From the vibrating of vocal cords to the striding of legs, it is by movements that actions are executed. Pain, on the other hand, along with other sensations, is on the receiving rather than output side. It is among the sensory mechanisms by which actions are generated; in particular, it prompts withdrawal from potentially harmful situations.

Pain, therefore, is integral to what Fulford, using Austin's phrase, calls the *machinery of action*. We will return shortly to Austin on the 'machinery of action' in the last reading in this chapter (see Exercise 23). But the point for now is to see that pain, no less than movement, is part of the machinery of action. It is a different part from movement, to be sure. But it is a part of the machinery, none the less. Hence, like movement-as-illness, pain-as-illness is eligible in principle for an action-failure analysis. Specifically, as Fulford goes on to argue, to the extent that pain prompts withdrawal, then, pain-as-illness is parallel to movement-as-illness in that *it can be understood as pain from which one is unable to withdraw in the perceived absence of obstruction and/or opposition*.

## Back to the map of mental illness

This way of understanding the experience of illness, as (or as derived from) a particular kind of failure of action, can be extended to the full range of illness experiences, mental as well as bodily, by considering these as involving different parts of the machinery of action.

That this 'machinery' is in principle rich enough (conceptually speaking) to encompass the full variety of illness experiences is evident from the next reading, a brief extract from Austin's *A Plea for Excuses* on this topic.

**EXERCISE 23** (20 minutes)

Read the extract from:

Austin, J.L. (1956–7). A plea for excuses. *Proceedings of the Aristotelian Society*, 57: 1–30. [Reprinted in White, A.R. (ed.) (1968). *The Philosophy of Action*. Oxford: Oxford University Press, pp. 19–42.] (Page numbers from reprint.)

Link with Reading 6.14

As you read through this long paragraph, 1) list any of the distinct parts of the 'machinery of action' mentioned by Austin, and 2) try to think what particular areas of psychopathology would correspond with (to extend Austin's metaphor) *failures* of each of these. (You may want to refer back to chapter 3 here.)

In the first part of this (very long) paragraph, Austin notes, among other parts of his 'machinery of action', attention (reduced in distractability in hypomania, for example), guarding against likely dangers (overactive in obsessional disorders), and 'judgement or tact' (again reduced in hypomania; also in 'frontal lobe syndrome').

Austin's purpose, here, is to illuminate excuses, i.e. as relying on ways in which our actions can 'go wrong'. All these, he says, are 'executive'. But there are also 'intelligence and planning', 'decision and resolve', and, a part of the machinery he distinguishes from all these, 'appreciation'. 'We can know the facts', he says, 'and yet look at them mistakenly or perversely, or . . . even be under a total misconception'. Here, he says, with failures of appreciation, 'troubles and excuses abound' (p. 34).

Austin's special mention of 'appreciation' turns out to be particularly relevant for understanding a key feature of the 'map' of mental disorder. You will recall from Chapter 2 that psychotic disorders, defined centrally by delusions, are the central case of mental illness as an excuse. Yet exactly why this should be so is far from clear: delusions, as we saw in Chapter 3, are not characteristically marked by any failure of the cognitive functions, such as memory and intelligence. Austin, although of course not concerned here with delusion as an excuse, gives us, in the concept of appreciation, as a part of the machinery of action distinct from knowledge, memory, intelligence and such like, a basis for explaining (or at any rate exploring) the distinct status of delusion as an excuse.

Thus, Fulford (1989, chapter 10), argues that the psychopathological features of delusion suggest that it should be understood as a failure of practical reasoning (i.e. the reasoning characteristic of whole persons as distinct from the particular cognitive part-functions of memory, IQ etc.); and in a widely used assessment measure of decision-making capacity, the MacCAT-T, developed by the psychiatrist Paul Appelbaum and the psychologist Thomas Grisso in the States, the loss of insight by which delusion is characterized is measured on a scale distinct from understanding and reasoning. And this distinct scale, in a neat coincidence with Austin's terminology, Grisso and Appelbaum actually call 'appreciation' (Grisso and Appelbaum, 1998).

### Many meanings of illness

Not only movement and pain, then, but a wide range of other sensations (and lack of sensations) can be analysed similarly, as can the far more diverse phenomena by which mental illness is constituted. Some of these phenomena are more like movement (thought, for example, and memory, as in the second part of Exercise 16); others are more like pain (anxiety, sadness, and so forth); none are *quite* the same, though, and some (like delusion) are altogether different.

Illness, then, the patient's actual experience, can be analysed in terms of a particular kind of action failure. The *similarities* between different kinds of illness experience, including those between mental and bodily illness, derive, on this analysis, from their common origins (conceptual origins) in action-failure; while the *differences* between them derive from differences in the way the phenomena concerned are built into the machinery of action.

This account, it is important to add, is not exclusive of function-based analyses of disease. As we have seen, action and function, failure of action and failure of function, are complementary. But if the indications we can take from Austin's (brief) account of the machinery of action are right, when it comes to understanding the diverse phenomena by which *mental* illness (include delusion) is constituted, action-failure, as well as function-failure, is essential.

## 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 are the features of the actual experience of illness? (We suggested four key features.)
2. Among the different kinds of actions (or things that a person does), which kind of action is particularly associated with early experiences of illness?
3. What objections might there be to analysing the experience of illness in terms of a particular kind of failure of action? We noted two objections.
4. How can an analysis of the experience of illness in terms of disturbance of agency be connected with an analysis of disease in terms of disturbance of functioning?
5. How can an analysis of the experience of illness in terms of a particular kind of disturbance of agency be generalized from movement (and loss of movement) to other kinds of illness experience?
6. What does an analysis of the experience of illness as a particular kind of disturbance of agency add to the traditional medical model?

## Conclusions: a full-field model and a two-way exchange

In this chapter we have looked at the outputs of philosophical work, at what we get out of doing philosophy. The broad conclusion has been that philosophy gives us a more complete picture (Wittgenstein's 'clearer view') of the meanings of the concepts in a given area of discourse.

### A full-field model

The more complete picture of the medical concepts to which we have come, and its relationship to the traditional medical model, is shown diagrammatically in figure 6.11

As the top half of this figure illustrates, a full-field model adds to, rather than subtracts from, the traditional medical model. It incorporates the medical model elements of fact, disease, and failure of functioning, but adds to these the elements of value, illness, and failure of action. This is why it is a 'full-field' model, incorporating both the traditional 'right field' of the medical model, and the 'left field' of illness experience, rather than suggesting that either field should exclude the other.

The inclusive (fact+value, etc) rather than exclusive nature of a full-field model is worth emphasizing. Too often science and the humanities are thought to be, somehow, antithetical in medicine. One could be forgiven for thinking this given the way in which scientifically minded doctors and ethicists often appear to be at loggerheads! But a full-field model incorporates everything that is genuinely scientific in medicine alongside and on an equal basis with everything that is genuinely humanistic.

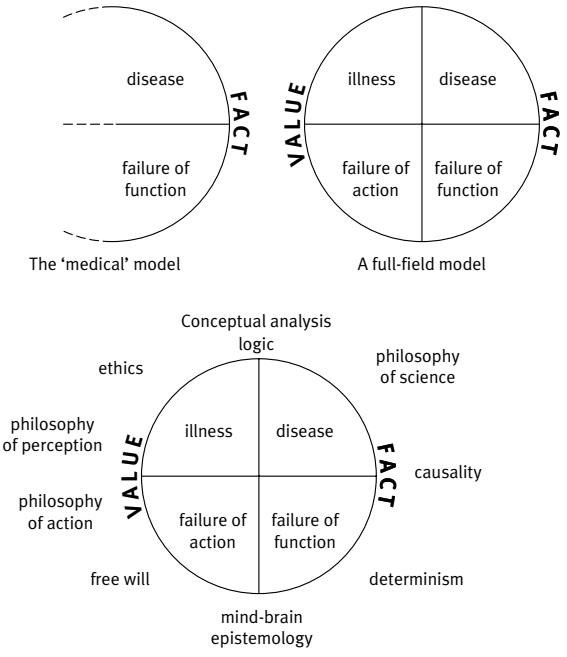


**Fig. 6.11** The full-field view and its philosophical context.

### Many methods

We have drawn in this chapter, as in earlier sections, particularly on Austinian 'fieldwork' as one method for building up this more complete picture, this clearer view, of our concepts. As we have seen, this is a powerful method. But as Austin himself emphasized, it is only one way of getting started with some kinds of philosophical problem. We noted in the last chapter the way in which Continental and Anglo-American methods are entirely complementary in coming to a more complete view of the 'logical geography' of illness. The bottom half of figure 6.11 illustrates the wide range of other philosophical disciplines that are relevant in this respect. Nor should philosophy as a whole be thought of as working in isolation. To the contrary, it is a natural partner of empirical and other research methods—thus we drew on empirical sociological work in session 3, for example.

### A two-way exchange

We will find many examples in this book of the ways in which, either directly, through giving us a clearer picture of the medical concepts, or indirectly, by drawing on more general philosophical topics, the clearer view offered by philosophy can contribute to good clinical work and research in mental health.

It is important, though, finally, to remind ourselves that, as we learned from Austin, Wilkes and others in Chapter 4, the 'outputs' of this clearer view, what we 'get out of it', is not a one-way flow from philosophy to practice. Just as important is the flow back from practice to philosophy.

## Reading guide

### Concepts of disorder: (4) Values and philosophical value theory

Hare's (1952) *The Language of Morals*, his first book, remains an excellent introduction to his approach. It was followed in 1963 by *Freedom and Reason* Hare, 1963a, and later in 1981 by *Moral Thinking: levels, methods and point*. He wrote extensively on descriptive and evaluative meaning, see for example, his article 'Descriptivism', first published in 1963 in *Proceedings of the British Academy* (Hare, 1963b); reprinted in Hare, R.M. (1972) *Essays on the Moral Concepts*. G.J. Warnock's (1971) version of descriptivism, which opposes Hare's prescriptivism, is set out in his *The Object of Morality*. Two accounts which defend the reduction of evaluative aspects of classification to the factual (naturalized) aspects are C.R. Pigden's (1993) 'Naturalism' in Peter Singer's, *A Companion to Ethics*; and

John Searle's contentious 'How to derive "ought" from "is" ', in Phillippa Foot's (1967), *Theories of Ethics*.

A useful brief introduction to the main philosophical views on the logical properties of value terms, and an excellent summary of the debates between descriptivist and non-descriptivist positions, is given in Geoffrey Warnock's (1967) *Contemporary Moral Philosophy*. As noted in chapter 2, the American philosopher, Hilary Putnam has recently (2002) set out an 'entanglement' view of the relationship between fact and value in his collection of essays, *The Collapse of the Fact/Value Dichotomy and other Essays*. Chapters 2–4 of Fulford's *Moral Theory and Medical Practice* (1989) explore the implications of this debate for our understanding of the concepts of illness and disease (as mixed fact-value concepts) in medicine and psychiatry. The applications of the debate specifically between non-descriptivist and descriptivist positions to the debate about mental illness, are set out in chapters 3 and 6 (corresponding to the first and second of the Hare extracts in this chapter of this book). A more complete treatment of a descriptivist version of the medical model is to be found in Fulford's (1995) chapter on 'Psychiatric ethics' in Almond's *Introducing Applied Ethics*.

The nature of the causal reduction is a large topic in its own right in the philosophy of science—see Reading Guides in Part III. For a discussion of causal reduction and its relevance to concepts of illness and disease, see Thornton, T. (2004) 'Reductionism/Antireductionism' in Radden's. (Ed) (2004) *The Philosophy of Psychiatry: a companion*. The complex relationship between illness and disease, including the way in which the ordinary usage of these terms is driven by their properties as value terms, is set out in chapters 2 and 4 of Fulford's *Moral Theory and Medical Practice*.

We will be returning to the relationship between facts (as in Hare's descriptive criteria) and values, both in their own right and as this is relevant to practical issues in mental health, at several points later in the book (in particular in Part IV).

## The experience of illness: sociological studies

In addition to David Locker's work as noted in the chapter, important sociological studies of illness behaviour and experience include Talcott Parsons' (1951) classic account of deviance and the way society uses the sick role to maintain stability; Robert Dingwall's (1976) study of illness in terms of social action; David Mechanic's (1981) 'The social dimension' work on the way in which illness behaviour is related to effective problem-solving (including delivery of health care); and work by labelling theorists, some of it offering radical critiques of mental illness (e.g. Pearson, 1975, *The Deviant Imagination*).

Early work on the cross-cultural aspects of the experience of illness includes Fabrega (1972) 'The study of disease in relation to culture'. Recent work, building on these early studies, includes Fitzpatrick et al's (1984) *The Experience of Illness*, Michael Calnan (1987) *Health and Illness: the lay perspective*; and Wendy Stainton Rogers (1992) *Explaining Illness*. A valuable edited collection is Marx and Johnson's (1991) *The Illness Experience: Dimensions of Suffering*.

## Values, agency, and illness

An account of the relationship between agency and values concerned with the concept of health, and hence with a different focus from that outlined in the chapter, has been developed by the Swedish philosopher, Lennart Nordenfelt (1987) in his *On the Nature of Health: an action-theoretic account of health*. This explores in detail the conceptual links between health, the 'vital goals' of the individual, and their biological and social origins. Nordenfelt's account fills in the social dimension of health. Although developed originally for bodily illness, Nordenfelt has extended his analysis to mental health in his *Talking about Health* (1997) and *Health, Science, and Ordinary Language* (2001).

The argument linking the experience of illness to loss of agency is developed in chapter 7 of Fulford's (1989) *Moral Theory and Medical Practice* and is extended to mental illness generally in chapter 8. (This includes the discussion of 'memory-as-illness', see Exercise 16.) The psychiatrist, Jeremy Holmes, and the philosopher, Richard Lindley (1989), have explored the relationship between values, agency and illness in psychotherapy in their *The Values of Psychotherapy*. The South African psychiatrist, Werdie Van Staden, has examined the relationship between recovery and agency in a linguistic-analytic study of first personal pronoun use in psychotherapy (Van Staden, 2002a; Van Staden and Fulford, 2004). Martins' *et al*. (2000) *Delusion According to the Speech Acts Theory*.

Two articles in the debate between Fulford and Nordenfelt have been published in the *Journal of Theoretical Medicine*—see especially, Fulford's (1993) 'Praxis makes perfect: illness as a bridge between biological concepts of disease and social conceptions of health'; also Fulford and Nordenfelt's contributions to Nordenfelt (2001) 'Health, science and ordinary language', respectively Nordenfelt's (2001) 'Toward a critical assessment of the reverse theories of health and illness' (pp. 75–112), and Fulford's (2001) 'Philosophy into practice: the case for ordinary language philosophy' (pp. 171–208) in Nordenfelt (2001).

Agency has been explored by a number of authors in *Philosophy, Psychiatry, & Psychology*. The first paper in the first issue of *Philosophy, Psychiatry, & Psychology* was on agency, Peter Binns' (1994) 'Affect, agency, engagement: conceptions of the person in philosophy, neuropsychiatry, and psychotherapy', with a response by Peter Caws (1994). Other papers on agency include, Campbell (2000a) 'Diagnosing agency', with a commentary by Loizzo (2000) 'Guarding patient agency', and a

response by Campbell (2000b) on 'Naturalizing agency'. A Special Issue of *Philosophy, Psychiatry, & Psychology*, guest edited by Melvin Woody, explores themes around 'Agency, narrative and self' (2003, issue 10/4). This issue was made up of an introduction by Sadler and Fulford (2003), and four target articles: Wells' (2003) 'Discontinuity in personal narrative: some perspectives of patients'; Kennett and Matthews (2003) on 'The unity and disunity of agency'; Phillips (2003) 'Psychopathology and the narrative self'; and Woody (2003) 'When narrative fails'. Commentaries on the set of four papers were provided by Glas (2003) on 'Loss of the self', Hardcastle (2003) on 'Emotions', Radden (2003) on 'Learning from disunity', Thornton (2003) on 'Two kinds of narrative accounts of the self', Weiner (2003) on volition, and Woodbridge (2003) on 'The forgotten self' (which covers the implications for training).

A novel analysis of the links between recovery and restoration of agency is Van Staden (2002a) on 'Linguistic markers of recovery: theoretical underpinnings of first person pronoun usage and semantic positions of patients', with commentaries by Gillett (2002), Suppes (2002), and Falzer and Davidson (2002), and a response by Van Staden (2002b). Van Staden's paper explores the philosophical underpinnings in Frege's logic of relations of the empirical work reported in Van Staden and Fulford (2004).

(See also Reading guide, Chapter 26.)

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