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On the Distinction between Disease and Illness

In this century a strong tendency has developed to debate social issues in psychiatric terms. Whether the topic is criminal responsibility, sexual deviance, feminism, or a host of others, claims about mental health are increasingly likely to be the focus of discussion. This growing preference for medicine over morals, which might be called the *psychiatric turn*, has an obvious appeal. In the paradigm health discipline, physiological medicine, judgments of health and disease are normally uncontroversial. The idea of reaching comparable certainty about difficult ethical problems is an inviting prospect. Unfortunately our grasp of the issues that surround the psychiatric turn continues to be impeded, as does psychiatric theory itself, by a fundamental misunderstanding of the concept of health. With few exceptions, clinicians and philosophers are agreed that health is an essentially evaluative notion. According to this consensus view, a value-free science of health is impossible. This thesis I believe to be entirely mistaken. I shall argue in this essay that it rests on a confusion between the theoretical and the practical senses of "health," or in other words, between disease and illness.

Two presuppositions of my whole discussion should be noted at the outset. The first is substantive: with Szasz and Flew, I shall assume that the idea of health ought to be analyzed by reference to physio-

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logical medicine alone.[1] It is a mistake to view physical and mental health as equally well-entrenched species of a single conceptual genus. In most respects, our institutions of mental health are recent offshoots from physiological medicine, and their nature and future are under continual controversy. In advance of a clear analysis of health in physiological medicine, it seems an open question whether current applications of the health vocabulary to mental conditions have any justification at all. Such applications will therefore be put on probation in the first two sections below. The other presupposition of my discussion is terminological. For convenience in distinguishing theoretical from practical uses of "health," I shall adhere to the technical usage of "disease" found in textbooks of medical theory. In such textbooks "disease" is simply synonymous with "unhealthy condition." Readers who wish to preserve the much narrower ordinary usage of "disease" should therefore substitute "theoretically unhealthy condition" throughout.

I. Normativism about Health

It is safe to begin any discussion of health by saying that health is normality, since the terms are interchangeable in clinical contexts. But this remark provides no analysis of health until one specifies the norms involved. The most obvious proposal, that they are pure statistical means, is widely recognized to be erroneous. On the one hand, many deviations from the average—e.g. unusual strength or vital capacity or eye color—are not unhealthy. On the other hand, practically everyone has some disease or other, and there are also particular diseases such as tooth decay and minor lung irritation that are nearly universal. Since statistical normality is therefore neither necessary nor sufficient for clinical normality, most writers take the following view about the norms of health: that they must be determined, in whole or in part, by acts of evaluation. More precisely, the orthodox view is that all judgments of health include value judgments as part of their meaning. To call a condition unhealthy is at least in part to condemn it; hence it is impossible to define health in nonevaluative terms. I shall refer to this orthodox view as *normativism.*

1. Thomas S. Szasz, *The Myth of Mental Illness* (New York, 1961); Antony Flew, *Crime or Disease?* (New York, 1973), pp. 40, 42.

Normativism has many varieties, which are often not clearly distinguished from one another by the clinicians who espouse them. The common feature of healthy conditions may, for example, be held to be either their desirability for the individual or their desirability for society. The gap between these two values is a persistent source of controversy in the mental-health domain. One especially common variety of normativism combines the thesis that health judgments are value judgments with ethical relativism. The resulting view that society is the final authority on what counts as disease is typical of psychiatric texts, as illustrated by the following quotation:

> While professionals have a major voice in influencing the judgment of society, it is the collective judgment of the larger social group that determines whether its members are to be viewed as sick or criminal, eccentric or immoral.[2]

For the most part my arguments against normativism will apply to all versions indiscriminately. It will, however, be useful to make a minimal division of normativist positions into strong and weak. Strong normativism will be the view that health judgments are pure evaluations without descriptive meaning; weak normativism allows such judgments a descriptive as well as a normative component.[3]

As an example of a virtually explicit statement of strong normativism by a clinician, consider Dr. Judd Marmor's remark in a recent psychiatric symposium on homosexuality:

> . . . to call homosexuality the result of disturbed sexual development really says nothing other than that you disapprove of the outcome of that development.[4]

If we may substitute "unhealthy" for "disturbed," Marmor is claiming that to call a condition unhealthy is *only* to express disapproval of it. In other words—to collapse a few ethical distinctions—for a condition

2. Ian Gregory, *Fundamentals of Psychiatry* (Philadelphia, 1968), p. 32.

3. R. M. Hare, in *Freedom and Reason* (New York, 1963), chap. 2, argues that no terms have prescriptive meaning alone. If this view is accepted, the difference between strong and weak normativism concerns the question of whether "healthy" is "primarily" or "secondarily" evaluative.

4. Judd Marmor, "Homosexuality and Cultural Value Systems," *American Journal of Psychiatry* 130 (1973): 1208.

to be unhealthy it is necessary and sufficient that it be bad. Now at least half of this view, the sufficiency claim, is demonstrably false of physiological medicine. It is undesirable to be moderately ugly or, for that matter, to lack the manual dexterity of Liszt, but neither of these conditions is a disease. In fact, there are undesirable conditions regularly corrected by physicians which are not diseases: Jewish nose, sagging breasts, adolescent fertility, and unwanted pregnancies are only a few of many examples. Thus strong normativism is an erroneous account of health judgments in their paradigm area of application, and its influence upon mental-health theorists is regrettable.

Unlike Marmor, however, many clinical writers take positions that can be construed as committing them merely to weak normativism. A good example is Dr. Marie Jahoda, who concludes her survey of current criteria of psychological health with these words:

> Actually, the discussion of the psychological meaning of various criteria could proceed without concern for value premises. Only as one calls these psychological phenomena "mental health" does the problem of values arise in full force. By this label, one asserts that these psychological attributes are "good." And, inevitably, the question is raised: Good for what? Good in terms of middle class ethics? Good for democracy? For the continuation of the social *status quo*? For the individual's happiness? For mankind? . . . For the encouragement of genius or of mediocrity and conformity? The list could be continued.[5]

Jahoda may here mean to claim only that calling a condition healthy *involves* calling it good. Her remarks are at least consistent with the weak normativist thesis that healthy conditions are good conditions which satisfy some further descriptive property as well. On this view, "healthy" is a mixed normative-descriptive term of the same sort as "honest" and "courageous." The following passage by Dr. F. C. Redlich is likewise consistent with the weak view:

5. Marie Jahoda, *Current Concepts of Positive Mental Health* (New York, 1958), pp. 76–77. See also her remark in *Interrelations Between the Social Environment and Psychiatric Disorders* (New York, 1953), p. 142: ". . . inevitably at some place there is a value judgment involved. I think that mental health or mental sickness cannot be conceived of without reference to some basic value."

> Most propositions about normal behavior refer implicitly or explicitly to ideal behavior. Deviations from the ideal obviously are fraught with value judgments; actually, all propositions on normality contain value statements in various degrees.[6]

Redlich's term "contain" suggests that he too sees the goodness of something as merely one necessary condition of its healthiness, and similarly for badness and unhealthiness.

Yet even weak normativism runs into counterexamples within physiological medicine. It is obvious that a disease may be on balance desirable, as with the flat feet of a draftee or the mild infection produced by inoculation. It might be suggested in response that diseases must at any rate be prima facie undesirable. The trouble with this suggestion is that it is obscure. Consider the case of a disease that has infertility as its sole important effect. In what sense is infertility prima facie undesirable? Considered in abstraction from the actual effects of reproduction on human beings, it is hard to see how infertility is either desirable or undesirable. Possibly those who see it as "prima facie" undesirable assume that most people want to be able to have more children. But the corollary of this position will be that writers of medical texts must do an empirical survey of human preferences to be sure that a condition is a disease. No such considerations seem to enter into human physiological research, any more than they do into standard biological studies of the diseases of plants and animals. Here indeed is another difficulty for any normativist, weak or strong. It seems clear that one may speak of diseases in plants and animals without judging the conditions in question undesirable. Biologists who study the diseases of fruit flies or sharks need not assume that their health is a good thing for us. On the other hand, there is not much sense in talking about the best interests of, say, a begonia. So it seems that normativists must interpret health judgments about plants and lower animals as analogical, in the same way as would be statements about the courage or considerateness of wolves and rats.

If normativism about health is at once so influential and so objectionable, one must ask what persuasive arguments there are in its

6. F. C. Redlich, "The Concept of Normality," *American Journal of Psychotherapy* 6 (1952): 553.

support. I know of only three arguments, of which one will be treated in the next section. A germ of an argument appears in the passage by Redlich just quoted. Health judgments involve a comparison to an ideal; hence, Redlich concludes, they are "fraught with value judgments." It seems evident, however, that Redlich is thinking of ideals such as beauty and holiness rather than the chemist's ideal gas or Weber's ideal bureaucrat. The fact that a gas or a bureaucrat deviates from the ideal type is nothing against the gas or the bureaucrat. There are normative and nonnormative ideals, as there are in fact normative and nonnormative norms. The question is which sort health is, and Redlich has here provided no grounds for an answer.

A second and equally incomplete argument for normativism is suggested by the first two chapters of Margolis' *Psychotherapy and Morality.*[7] Margolis argues in his first chapter that psychoanalysts have been mistaken in holding that their therapeutic activities can "escape moral scrutiny" (p. 13). From this he concludes that "it is reasonable to view therapeutic values as forming part of a larger system of moral values" (p. 37), and explicitly endorses normativism. But this inference is a non sequitur. From the fact that the promotion of health is open to moral review, it in no way follows that health judgments are value judgments. Wealth and power are also "values" in the sense that people pursue them in a morally criticizable fashion; neither is a normative concept. The pursuit of any descriptively definable condition, if it has effects on persons, will be open to moral review.

These two arguments, like the health literature generally, do next to nothing to rule out the alternative view that health is a descriptively definable property which is usually valuable. Why, after all, may not health be a concept of the same sort as intelligence, or deductive validity? Though the idea of intelligence is certainly vague, it does not seem to be normative. Intelligence is the ability to perform certain intellectual tasks, and one would expect that these intellectual tasks could be characterized without presupposing their value.[8] Similarly, a

7. Joseph Margolis, *Psychotherapy and Morality* (New York, 1966).

8. Exactly what intellectual abilities are included in intelligence is, of course, unclear and may vary from culture to culture. (See N. J. Block and Gerald Dworkin, "IQ, Heritability and Inequality, Part I," *Philosophy and Public Affairs*

valid argument may, for theoretical purposes, be descriptively defined[9] roughly as one that has a form no instance of which could have true premises and a false conclusion. Intelligence in people and validity in arguments being generally valued, the statement that a person is intelligent or an argument valid does tend to have the force of a recommendation. But this fact is wholly irrelevant to the employment of the terms in theories of intelligence or validity. To insist that evaluation is still part of the very meaning of the terms would be to make an implausible claim to which there are obvious counterexamples. Exactly the same may be true of the concept of health. At any rate, we have already seen some of the counterexamples.

Since the distinction between force and meaning in philosophy of language is in a rather primitive state, it is doubtful that weak normativism about health can be either decisively refuted or decisively established. But I suggest that its current prevalence is largely the result of two quite tractable causes. One is the lack of a plausible descriptive analysis; the other is a confusion between theoretical and practical uses of the health vocabulary. The required descriptive analysis I shall try to sketch in the next section. As for the second cause, one should always remember that a dual commitment to theory and practice is one of the features that distinguish a clinical discipline. Unlike chemists or astronomers, physicians and psychotherapists are professionally engaged in practical judgments about how certain people ought to be treated. It would not be surprising if the terms in which such practical judgments are formulated have normative content. One might contend, for example, that calling a cancer "inoperable" involves the value judgment that the results of operating will be worse than leaving the disease alone. But behind this conceptual framework of medical practice stands an autonomous framework of medical theory, a body of doctrine that describes the functioning of a healthy body, classifies various deviations from such functioning as

3, no. 4 [Summer 1974]: 333.) But this does not show that for any particular group of speakers "intelligent" is a normative term, i.e. has positive evaluation as part of its meaning.

9. The contrary view, which might be called normativism about validity, is defended by J. O. Urmson in "Some Questions Concerning Validity," *Revue Internationale de Philosophie* 25 (1953): 217–229.

diseases, predicts their behavior under various forms of treatment, etc. This theoretical corpus looks in every way continuous with theory in biology and the other natural sciences, and I believe it to be value-free.

The difference between the two frameworks emerges most clearly in the distinction between disease and illness. It is disease, the theoretical concept, that applies indifferently to organisms of all species. That is because, as we shall see, it is to be analyzed in biological rather than ethical terms. The point is that illnesses are merely a subclass of diseases, namely, those diseases that have certain normative features reflected in the institutions of medical practice. An illness must be, first, a reasonably *serious* disease with incapacitating effects that make it undesirable. A shaving cut or mild athlete's foot cannot be called an illness, nor could one call in sick on the basis of a single dental cavity, though all these conditions are diseases. Secondly, to call a disease an illness is to view its owner as deserving special treatment and diminished moral accountability. These requirements of "illness" will be discussed in some detail shortly, with particular attention to "mental illness." But they explain at once why the notion of illness does not apply to plants and animals. Where we do not make the appropriate normative judgments or activate the social institutions, no amount of disease will lead us to use the term "ill." Even if the laboratory fruit flies fly in listless circles and expire at our feet, we do not say they succumbed to an illness, and for roughly the same reasons as we decline to give them a proper funeral.

There are, then, two senses of "health." In one sense it is a theoretical notion, the opposite of "disease." In another sense it is a practical or mixed ethical notion, the opposite of "illness."[10] Let us now examine the relation between these two concepts more closely.

II. Disease and Illness

What is the theoretical notion of a disease? An admirable explanation of clinical normality was given thirty years ago by C. Daly King.

10. Thomas Nagel has suggested that the adjective "ill" may have its own special opposite "well." Our thinking about health might be greatly clarified if "wellness" had some currency.

> The normal . . . is objectively, and properly, to be defined as that which functions in accordance with its design.[11]

The root idea of this account is that the normal is the natural. The state of an organism is theoretically healthy, i.e. free of disease, insofar as its mode of functioning conforms to the natural design of that kind of organism. Philosophers have, of course, grown repugnant to the idea of natural design since its cooptation by natural-purpose ethics and the so-called argument from design. It is undeniable that the term "natural" is often given an evaluative force. Shakespeare as well as Roman Catholicism is full of such usages, and they survive as well in the strictures of state legislatures against "unnatural acts." But it is no part of biological theory to assume that what is natural is desirable, still less the product of divine artifice. Contemporary biology employs a version of the idea of natural design that seems ideal for the analysis of health.

The crucial element in the idea of a biological design is the notion of a natural function. I have argued elsewhere that a function in the biologist's sense is nothing but a standard causal contribution to a goal actually pursued by the organism.[12] Organisms are vast assemblages of systems and subsystems which, in most members of a species, work together harmoniously in such a way as to achieve a hierarchy of goals. Cells are goal-directed toward metabolism, elimination, and mitosis; the heart is goal-directed toward supplying the rest of the body with blood; and the whole organism is goal-directed both to particular activities like eating and moving around and to higher-level goals such as survival and reproduction. The specifically physiological functions of any component are, I think, its species-typical contributions to the apical goals of survival and reproduction. But whatever the correct analysis of function statements, there is no doubt that biological theory is deeply committed to attributing functions to processes in plants and animals. And the single unifying property of all recognized

11. C. Daly King, "The Meaning of Normal," *Yale Journal of Biology and Medicine* 17 (1945): 493–494. Most definitions of health in medical dictionaries include some reference to functions. Almost exactly King's formulation also appears in Fredrick C. Redlich and Daniel X. Freedman, *The Theory and Practice of Psychiatry* (New York, 1966), p. 113.

12. "Wright on Functions," to appear in *The Philosophical Review*.

diseases of plants and animals appears to be this: that they interfere with one or more functions typically performed within members of the species.

The account of health thus suggested is in one sense thoroughly Platonic. The health of an organism consists in the performance by each part of its natural function. And as Plato also saw, one of the most interesting features of the analysis is that it applies without alteration to mental health as long as there are standard mental functions. In another way, however, the classical heritage is misleading, for it seems clear that biological function statements are descriptive rather than normative claims.[13] Physiologists obtain their functional doctrines without at any stage having to answer such questions as, What is the function of a man? or to explicate "a good man" on the analogy of "a good knife." Functions are not attributed in this context to the whole organism at all, but only to its parts, and the functions of a part are its causal contributions to empirically given goals. What goals a type of organism in fact pursues, and by what functions it pursues them, can be decided without considering the value of pursuing them. Consequently health in the theoretical sense is an equally value-free concept. The notion required for an analysis of health is not that of a good man or a good shark, but that of a good specimen of a human being or shark.

All of this amounts to saying that the epistemology King suggested for health judgments is, at bottom, a statistical one. The question therefore arises how the functional account avoids our earlier objections to statistical normality. King did explain how to dissolve one version of the paradox of saying that everyone is unhealthy. Clearly all the members of a species can have some disease or other as long as they do not have the same disease. King somewhat grimly compares the job of extracting an empirical ideal of health from a set of defec-

13. The view that function statements are normative generates the third argument for normativism. It is presented most fully by Margolis in "Illness and Medical Values," *The Philosophy Forum* 8 (1959): 55–76, section II. It is also suggested by Ronald B. de Sousa, "The Politics of Mental Illness," *Inquiry* 15 (1972): 187–201, p. 194, and possibly by Flew as well in *Crime or Disease?* pp. 39–40. I think philosophers of science have made too much progress in giving biological function statements a descriptive analysis for this argument to be very convincing.

tive specimens to the job of reconstructing the Norden bombsight from assorted aerial debris (p. 495). But this answer does not touch universal diseases such as tooth decay. Although King nowhere considers this objection, the natural-design idea nevertheless suggests an answer that I suspect is correct. If what makes a condition a disease is its deviation from the natural functional organization of the species, then in calling tooth decay a disease we are saying that it is not simply in the nature of the species—and we say this because we think of it as mainly due to environmental causes. In general, deficiencies in the functional efficiency of the body are diseases when they are unnatural, and they may be unnatural either by being atypical or by being attributable mainly to the action of a hostile environment. If this explanation is accepted,[14] then the functional account simultaneously avoids the pitfalls of statistical normality and also frees the idea of theoretical health of all normative content.

Theoretical health now turns out to be strictly analogous to the mechanical condition of an artifact. Despite appearances, "perfect mechanical condition" in, say, a 1965 Volkswagen is a descriptive notion. Such an artifact is in perfect mechanical condition when it conforms in all respects to the designer's detailed specifications. Normative interests play a crucial role, of course, in the initial choice of the design. But what the Volkswagen design actually *is* is an empirical matter by the time production begins. Thenceforward a car may be in perfect condition regardless of whether the design is good or bad. If one replaces its stock carburetor with a high-performance part, one may well produce a better car, but one does not produce a Volkswagen in better mechanical condition. Similarly, an automatic camera may function perfectly and take wretched pictures; guided missiles and instruments of torture in perfect mechanical condition may serve execrable ends. Perfect working order is a matter not of the worth of the product but of the conformity of the process to a fixed design. In the case of organisms, of course, the ideal of health must be determined by empirical analysis of the species rather than by the intentions of a designer. But otherwise the parallel seems exact. A person who by

14. For further discussion of environmental injuries and other details of the functional account of health sketched in this section, see my forthcoming essay "Health as a Theoretical Concept."

mutation acquires a sixth sense, or the ability to regenerate severed limbs, is not thereby healthier than we are. Sixth senses and limb regeneration are not part of the human design, which at any given time, for better or worse, just is what it is.

We have been arguing that health is descriptively definable within medical theory, as intelligence is in psychological theory or validity in logical theory. Nevertheless medical theory is the basis of medical practice, and medical practice unquestioningly presupposes the value of health. We must therefore ask how the functional view explains this presumption that health is desirable.

In the case of physiological health, there are at least two general reasons why the functional normality that defines it is usually worth having. In the first place, most people do want to pursue the goals with respect to which physiological functions are isolated. Not only do we want to survive and reproduce, but we also want to engage in those particular activities, such as eating and sex, by which these goals are typically achieved. In the second place—and this is surely the main reason the value of physical health seems indisputable—physiological functions tend to contribute to all manner of activities neutrally. Whether it is desirable for one's heart to pump, one's stomach to digest, or one's kidneys to eliminate hardly depends at all on what one wants to do. It follows that essentially all serious physiological diseases will satisfy the first requirement of an illness, namely, undesirability for its bearer.

This explanation of the fit between medical theory and medical practice has the virtue of reminding us that health, though an important value, is conceptually a very limited one. Health is not unconditionally worth promoting, nor is what is worth promoting necessarily health. Although mental-health writers are especially prone to ignore these points, even the constitution of the World Health Organization seems to embody a similar confusion:

> Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.[15]

Unless one is to abandon the physiological paradigm altogether, this definition is far too wide. Health is functional normality, and as such

15. Quoted by Flew, *Crime or Disease?* p. 46.

is desirable exactly insofar as it promotes goals one can justify on independent grounds. But there is presumably no intrinsic value in having the functional organization typical of a species if the same goals can be better achieved by other means. A sixth sense, for example, would increase our goal-efficiency without increasing our health; so might the amputation of our legs at the knee and their replacement by a nuclear-powered air-cushion vehicle. Conversely, as we have seen, there is no a priori reason why ordinary diseases cannot contribute to well-being under appropriate circumstances.

In such cases, however, we will be reluctant to describe the person involved as ill, and that is because the term "ill" *does* have a negative evaluation built into it. Here again a comparison between health and other properties will be helpful. Disease and illness are related somewhat as are low intelligence and stupidity, or failure to tell the truth and speaking dishonestly. Sometimes the presumption that intelligence is desirable will fail, as in a discussion of qualifications for a menial job such as washing dishes or assembling auto parts. In such a context a person of low intelligence is unlikely to be described as stupid. Sometimes the presumption that truth should be told will fail, as when the Gestapo inquires about the Jews in your attic. Here the untruthful householder will not be described as speaking dishonestly. And sometimes the presumption that diseases are undesirable will fail, as with alcoholic intoxication or mild rubella intentionally contracted. Here the term "illness" is unlikely to appear despite the presence of disease. One concept of each pair is descriptive; the other adds to the first evaluative content, and so may be withheld where the first applies.

If we supplement this condition of undesirability with two further normative conditions, I believe we have the beginning of a plausible analysis of "illness."

> A disease is an *illness* only if it is serious enough to be incapacitating, and therefore is
>
> (i) undesirable for its bearer;
>
> (ii) a title to special treatment; and
>
> (iii) a valid excuse for normally criticizable behavior.

The motivation for condition (ii) needs no explanation. As for (iii), the connection between illness and diminished responsibility has often

been argued,[16] and I shall mention here only one suggestive point. Our notion of illness belongs to the ordinary conceptual scheme of persons and their actions, and it was developed to apply to physiological diseases. Consequently the relation between persons and their illnesses is conceived on the model of their relation to their bodies. It has often been observed that physiological processes, e.g. digestion or peristalsis, do not usually count as actions of ours at all. By the same token, we are not usually held responsible for the results of such processes when they go wrong, though we may be blamed for failing to take steps to prevent malfunction at some earlier time. Now if this special relation between persons and their bodies is the reason for connecting disease with nonresponsibility, the connection may break down when diseases of the mind are at stake instead. I shall now argue, in fact, that conditions (i), (ii), and (iii) all present difficulties in the domain of mental health.

III. Mental Illness

For the sake of discussion, let us simply assume that the mental conditions usually called pathological are in fact unhealthy by the theoretical standard sketched in the last section. That is, we shall assume both that there are natural mental functions and also that recognized types of psychopathology are unnatural interferences with these functions.[17] Is it reasonable to make a parallel extension of the vocabulary of medical practice by calling these mental diseases mental illnesses? Let us consider each condition on "illness."

Condition (i) was the undesirability of an illness for its bearer. Now there are obstacles to transferring our general arguments that physiological health is desirable to the psychological domain. Mental states are not nearly so neutral to the choice of actions as physiological states are. In particular, to evaluate the desirability of mental health

16. A good discussion of this point and of the undesirability condition (i) is provided by Flew in the extremely illuminating second chapter of *Crime or Disease*? Flew takes these conditions as part of the meaning of "disease" rather than "illness"; but since he seems to be working from the ordinary usage of "disease," there may be no real disagreement here.

17. The plausibility of these two claims is discussed at length in my essay, "What a Theory of Mental Health Should Be," to appear in *Journal for the Theory of Social Behaviour.*

we can hardly avoid consulting our desires; but in the mental-health context it could be those very desires that are judged unhealthy. From a theoretical standpoint desires must be assigned a motivational function in producing action. Thus our wants may or may not conform to the species design. But if our wants do not conform to the species design, it is not immediately obvious why we should want them to. If there is no good reason to want them to, then we have a disease which is not an illness. It is conceivable that this divergence between the two notions is illustrated by homosexuality. It can hardly be denied that one normal function of sexual desire is to promote reproduction. If one does not have a desire for heterosexual sex, however, the only good reason for wanting to have such a desire seems to be that one would be happier if one did. But this judgment needs to be supported by evidence. The desirability of having species-typical desires is not nearly so obvious on inspection as the desirability of having species-typical physiological functions.

One of the corollaries of this point is that recent debates over homosexuality and other disputable diagnoses usually ignore at least one important issue. Besides asking whether, say, homosexuality is a disease, one should also ask what difference it makes if it is. I have suggested that biological normality is an instrumental rather than an intrinsic good. We always have the right to ask, of normality, what is in it for us that we already desire. If it were possible, then, to maximize intrinsic goods such as happiness, for ourselves and others, with a psyche full of deviant desires and unnatural acts, it is hard to see what practical significance the theoretical judgment of unhealthiness would have. I do not actually have serious doubts that disorders such as neuroses and psychoses diminish human happiness. It is also true that what is desirable for a person need not coincide with what the person wants; though an anorectic may not wish to eat, it is desirable that he or she do so. But we must be clear that requests to justify the value of health in other terms are always in order, and there are reasons to expect that such justification will require more evidence in the psychological domain than in the physiological.

We have been discussing the value of psychological normality for the individual, as dictated by condition (i) on illness, rather than its desirability for society at large. Since clinicians often assume that

mental health involves social adjustment, it may be well to point out that the functional account of health shows this too to be a debatable assumption requiring empirical support. Certainly nothing in the mere statement that a person has a mental disease entails that he or she is contributing less to the social order than an arbitrary normal individual. There is no contradiction in calling van Gogh or Blake or Dostoyevsky mentally disturbed while admiring their work, even if they would have been less creative had they been healthier. Conversely, there is no a priori reason to assume that the healthy human personality will be morally worthy or socially acceptable. If Freud and Lorenz are right about the existence of an aggressive drive, there is a large component of the normal psyche that is less than admirable. Whether or not they are right, the suggestion clearly makes sense. Perhaps most psychiatrists would agree anyway that antisocial behavior is to be expected during certain developmental stages, e.g. the so-called anal-sadistic period or adolescence.

It must be conceded that *Homo sapiens* is a social species. Other organisms of this class, such as ants and bees, display elaborate fixed systems of social adaptations, and it would be remarkable if the human design included no standard functions at all promoting socialization. On the basis of the physiological paradigm, however, it is not at all clear that contributions to society can be viewed as requirements of health except when they also contribute to individual survival and reproduction. No matter how this issue is decided, the crucial point remains: the nature and extent of social functions in the human species can be discovered only empirically. Despite the contrary convictions of many clinicians, the concept of mental health itself provides no guarantee that healthy individuals will meet the standards or serve the interests of society at large. If it did, that would be one more reason to question the desirability of health for the individual.

Let us now go on to condition (ii) on a disease which is an illness: that it justify "special treatment" of its owner. It is this condition together with (iii) that gives some plausibility to the many recent attempts to explain mental illness as a "social status" or "role."[18] The

18. An example of this approach is Robert B. Edgerton, "On The 'Recognition' of Mental Illness," in Stanley C. Plog and Robert B. Edgerton, *Changing Perspectives in Mental Illness* (New York, 1969), pp. 49–72.

idea that the "sick role" is a special one is consistent with the statistical normality of having some disease or other. Since illnesses are serious diseases that incapacitate at the level of gross behavior, everyone can be minimally diseased without being ill. In the realm of mental health, however, many psychiatrists suggest the stronger thesis that it is statistically normal to be significantly incapacitated by neurosis.[19] A similar problem may arise on Benedict's famous view that the characteristic personality type of some whole societies is clinically paranoid.[20] A statistically normal condition, according to our analysis, can be a disease only if it can be blamed on the environment. But one might plausibly claim that most or all existing *cultural* environments do injure children, filling their minds with excessive anxiety about sexual pleasure, grotesque role models, absurd prejudices about reality, etc. It is at least possible that some degree of neurosis or psychosis is a nearly universal environmental injury in our species. Only an empirical inquiry into the incidence and etiology of neurosis can show whether this possibility is a reality. If it is, however, one can maintain the idea that serious diseases are illnesses only by abandoning one of the presuppositions of the illness concept: that not everyone can be ill.[21]

The last and clearest difficulty with "mental illness" concerns condition (iii), the role of illness in excusing conduct. We said that the idea that serious diseases excuse conduct derives from the model of

19. Only one example of this suggestion is Dr. Reuben Fine's statement that neurosis afflicts 99 percent of the population. See Fine's "The Goals of Psychoanalysis," in *The Goals of Psychotherapy*, ed. Alvin R. Mahrer (New York, 1967), p. 95. I consider the issue of whether all neurosis can be called unhealthy in the essay cited in note 16.

20. See the descriptions of the Kwakiutl and the Dobu in Ruth Benedict, *Patterns of Culture* (Boston: Houghton Mifflin, 1934).

21. A number of clinicians have seriously suggested that people who are ill can be distinguished from those who are well by their presence in your office. One such author goes as far as to calculate an upper limit on the incidence of mental illness from the number of members in the American Psychiatric Association. On a literal reading, this patient-in-the-office test implies that one could wipe out mental illness once and for all by dissolving the APA and outlawing psychotherapy. But the whole idea seems silly anyway in the face of various studies that indicate that the population at large is, by the ordinary descriptive criteria for mental disorder, no less disturbed than the population of clinical patients.

the relation of agents to their own physiology. Unfortunately the relation of agents to their own psychology is of a much more intimate kind. The puzzle about mental illness is that it seems to be an activity of the very seat of responsibility—the mind and character—and therefore to be beyond all hope of excuse.

This inference is hardly inescapable; there is room for considerable controversy to which I cannot do justice here. Strictly speaking, mental disorders are disturbances of the personality. It is persons, not personalities, who are held responsible for actions, and one central element in the idea of a person is certainly consciousness. This means that there may be some sense in contrasting responsible persons with their mental diseases insofar as these diseases lie outside their conscious personalities. Perhaps from a psychoanalytic standpoint this condition is often met in psychosis and neurosis. The unconscious processes that surface in these disorders seem at first sight more like things that happen within us, e.g. peristalsis, than like things we do. But several points make this classification look oversimplified. Unconscious ideas and wishes are still *our* ideas and wishes in a more compelling sense than movements of the gut are our movements. They may have been conscious at an earlier time or be made conscious in therapy, whereupon it becomes increasingly difficult to disclaim responsibility for them. It seems quite unclear that we are more responsible for many conscious desires and beliefs than for these unconscious ones. Finally, the hope for contrasting responsible people with their mental diseases grows vanishingly dim in the case of a character disorder, where the unhealthy condition seems to be integrated into the conscious personality.

In view of these points and the rest of the discussion, I think we must accept the following conclusion. While conditions (i), (ii), and (iii) apply fairly automatically to serious physical diseases, not one of them should be assumed to apply automatically to serious mental diseases. If the term "mental illness" is to be applied at all, it should probably be restricted to psychoses and disabling neuroses. But even this decision needs more analysis than I have provided in this essay. It seems doubtful that on any construal mental illness will ever be, in the mental-health movement's famous phrase, "just like any other illness."

What are the implications of our discussion for the social issues to which psychiatry is so frequently applied? As far as the criminal law is concerned, our results suggest that psychiatric theory alone should not be expected to define legal responsibility, e.g. in the insanity defense.[22] Although the notion of responsibility is a component of the notion of illness, it belongs not to medical theory but to ethics, and one can fix its boundaries only by rational ethical debate. It seems certain that such a simple responsibility test as that the act of the accused not be "the product of mental disease" is unsatisfactory. No doubt many of us have antisocial tendencies that derive from underlying psychopathology of an ordinary sort. When these tendencies erupt in a parking violation or negligent collision, it hardly seems inhumane or unjust to apply legal sanctions.[23] But this is not surprising, for no psychiatric concept is properly designed to answer moral questions. I am not saying that psychiatry is irrelevant to law and ethics. Anyone writing or applying a criminal code is certainly well advised to obtain the best available information about human nature, including the information about human nature that constitutes mental-health theory. The point is that one cannot expect to substitute psychiatry for moral debate, any more than moral evaluations can be substituted for psychiatric theory. Insofar as the psychiatric turn consists in such substitutions, it is fundamentally misconceived.

The other main implications of our discussion seem to me twofold. First, there is not the slightest warrant for the recurrent fantasy that what society or its professionals disapprove of is ipso facto unhealthy. This is not merely because society may disapprove of the wrong things. Even if ethical relativism were true, society still could not fix the functional organization of the members of a species. For this reason it could never be an infallible authority either on disease or on illness, which is a subclass of disease. Thus one main source of the

22. The same conclusion is defended by Herbert Fingarette in "Insanity and Responsibility," *Inquiry* 15 (1972): 6–29.

23. Thus I disagree with H.L.A. Hart, among others, who writes: ". . . the contention that it is fair or just to punish those who have broken the law must be absurd if the crime is merely a manifestation of a disease." The quotation is from "Murder and the Principles of Punishment: England and the United States," reprinted in *Moral Problems*, ed. James Rachels (New York, 1975), p. 274.

tendency to call radical activists, bohemians, feminists, and other unpopular deviants "sick" is nothing but a conceptual confusion.

The second moral suggested by our discussion is that it is always worth asking, in any particular case, how strong the presumption is that health is desirable. When the value of health is left both unquestioned and obscure, it has a tendency to undergo inflation. The diagnosis especially of a "mental illness" is then likely to become an amorphous and peculiarly repellent stigma to be removed at any cost. The use of muscle-paralyzing drugs to compel prisoners to participate in "group therapy" is a particularly gruesome example of this sort of thinking.[24] But there are many other situations in which everyone would profit by asking what exactly is wrong with being unhealthy. In a way liberal reformers tend to make the opposite mistake: in their zeal to remove the stigma of disease from conditions such as homosexuality, they wholly discount the possibility that these conditions, like most diseases, are somewhat unideal. If the value of health, as I have argued in this essay, is nothing but the value of conformity to a generally excellent species design, then by recognizing that fact we may improve both the clarity and the humanity of our social discourse.

24. For this and other "therapeutic" abuses in our prison system, see Jessica Mitford, *Kind and Usual Punishment* (New York, 1973), chap. 8.