MENTAL ILLNESS AS A MORAL CONCEPT

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The concept of mental illness has been the subject of heated controversy in recent years; and this debate has caught the attention of a wide public. The reason for this is not simply that the debate has sometimes been conducted in heated terms; but, more importantly, because it has raised central moral and social issues which are of fundamental concern. And it is in this respect - as an aspect of contemporary moral and social thought - that I wish to look at this controversy in this paper.

Even this intention requires some justification, however, since moral philosophers have tended to ignore it or simply parrot what psychiatrists have to say about it, while most psychiatrists would dispute that their ideas on mental illness have any *moral* significance. Thus it is common for psychiatrists to regard their work as a kind of technology, which is seen as a means for producing a certain result (*viz.* mental health) which can be objectively defined. And it is often argued that just because the goal of therapy is 'objectively defineable', the only relevant criterion for evaluating the success of therapy is in terms of its *efficiency* in achieving this 'objectively defined' goal, and therefore that moral considerations do not play any part. According to this view then, which I shall call the 'psychiatric account', a judgement of illness is not a value-judgement, but an objective and factual one; and psychiatric theory is a scientific theory which neither raises nor answers any moral questions.

Broadly speaking, two sorts of criteria have been suggested in the attempt to define such an 'objective' concept of mental illness: statistical and clinical. [1]

According to the statistical approach, mental illness is to be defined in relation to statistical norms. The main advantage claimed for this sort of definition is that it involves precise, empirical criteria. Thus, for example, Jaspers writes:

> The only thing in common [to the various states thought of as 'illness'] is that a value-judgement is expressed. In some sense, but not always the same sense, 'sick' implies something harmful, unwanted and of an inferior character. If we want to get away from value-concepts and value-judgements of this sort we have to look for an empirical concept of what sickness is. The <u>concept of the average</u> affords us such a concept... The concept of the average is an empirical concept of what concretely *is*.
> [2]

So Jaspers proposes to define illness as deviation from the average and imagines that by so doing he has produced a non-evaluative concept of illness. He is assuming that any concept with objectively specifiable criteria is a non-evaluative one, but this is a crass error about the nature of value judgements which even our contemporary moral philosophers have avoided. [3] Just because precise and objective criteria can be specified for being Jewish it does not follow that anti-Semitism involves no value-judgements.

Health and illness are *practical* concepts and the need for them arises in the practical context of therapy. A purely theoretical science does not require them, but in the practical, medical sciences they are necessary to specify the goal and object of therapy. And so long as health continues to specify the goals of therapy, and illness continues to specify what is to be eradicated through therapy, these concepts will be evaluative ones, regardless of whether these goals are precisely defined in empirical terms. These remarks apply to the concepts of health and illness in general. In the specific case of mental health and illness, the value-judgements involved concern a person's actions and rationality and his relationship with others. There are good grounds, therefore, for regarding mental illness as a moral concept. [4] In the light of this, the statistical approach is clearly unsatisfactory: it seems to put an arbitrary value upon 'the average' and claim a mysterious objectivity for itself in doing so.

The virtue of objectivity is also claimed for the clinical approach, which is altogether a more sophisticated one according to which illness is *improper* or *abnormal* functioning. This view is best explained in terms of a frequently used analogy between curing an illness and repairing a machine.

According to this analogy, the doctor (either in general medicine or in psychiatry) is like a mechanic repairing a car. Just as the mechanic restores the car to its *normal* or *proper* functioning, so the doctor in his treatment is supposed to be restoring a person to his normal functioning and righting the abnormalities in his performance. The success of this analogy depends upon the applicability of the notion of function in both cases. There is little problem in talking of the function of a car, since a car is a human product and it is produced *as* something with a function, as a means of transport. Furthermore, it, is not difficult to see how the practice of physical medicine may be viewed in terms of this analogy. Although the body is not a human product and its ,

1 These terms are taken from F C Redlich and D X Freedman, *The Theory and Practice of Psychiatry*, Basic Books Inc, NY, USA, 1966.

2 K Jaspers, *General Psychopathology*, Manchester UP, pp.780-1.

3 Cf. R M Hare, *Freedom and Reason*, OUP, 1963; Philippa Foot, 'Moral Beliefs' in *PAS 59*, 1958-9 etc., discussion of words like 'rude' and 'nigger'.

4 See also J Margolis, *Psychotherapy and Morality*, Random House, 1966, esp. Ch.1 for further arguments.

function is not therefore, in that sense, man-given, it often seems an uncontroversial matter to specify the basic functions which the body should fulfil and to decide whether it is functioning properly according to these standards. [5]

The problems of extending this mechanical anlogy to the field of psychiatry are, however, much greater; for we must now consider the question of the function, not just of the *body*, but of the *person*. This question can be interpreted more or less widely. Interpreted most widely, it poses the classical question of moral philosophy: what is the end of life? - What is human fulfilment? I shall try to show how later. However, those psychiatrists who have adopted what I have called the 'clinical approach' have typically interpreted this question in the narrowest fashion. Thus, at the most basic level, it seems possible to say that a person is given a function by virtue of his particular role as a member of society, and that his function is to fulfil this role. Any person who cannot maintain a social role fails according to these minimal standards, and becomes a dyafunctional social unit, a 'deviant'. Clearly *idealism* is not one of the virtues of this account of the function of a person; however, a certain basic *realism* is. To live in a society one must function in a certain fashion. Most people have large demands made upon them by their social lives - they must have the ability to feed, house, clothe and protect themselves and so on with whatever help is available to them. [6]

From this line of thought about the function of a person arises the idea that mental illness is a failure *in a society*; and illness thus defined, as a form of social deviation, is a socially relative concept. The society and the individual's role within it are assumed to be normal (that is to say 'healthy': 'normality' is a common synonym for 'health' in psychiatry as in other areas of medicine). Indeed, the prevailing social environment is made the very criterion of normality, and the individual is judged ill insofar as he fails to 'adjust' to it. [7]

This clinical account of mental illness claims to be an objective one because mental illness and health are defined in terms of a person's function, and this appears to be a matter of objective fact. A part, at least, of a person's function - his social role - seems to be objectively given to him by the very fact of his social life. The social demands upon the individual are real ones, which must be able to meet for his social survival. If he cannot meet these demands, he becomes socially incapacitated and either he will seek 'help' or 'help' will be sought for him, at first probably from his family and friends, and ultimately perhaps from a psychiatrist. In this way, the psychiatrist's task appears to be given to

him objectively by the society in which he and his patient live.

I have tried to present this argument with sympathy - indeed I recognize the importance of the considerations it raises, as will become apparent. However, the argument clearly fails in its purpose; namely to found the value-judgements implicit in the concept of mental illness securely upon a basis of objective fact. Just because the individual *is* a part of society, and just because this society *does* make real demands upon him, it does not therefore follow that these demands are to be valued as 'healthy'. What happens in the clinical account is that the prevailing social conditions are taken as fixed and given, and made the criterion of value upon which the account of health and illness is founded. What is valued is equated with what exists - However, this does not found these values on a factual basis; rather, it places a value upon things as they in fact are. Such an attempt to base the value-judgement implicit in the concepts of health and illness upon the foundation of 'what exists' (to use Jaspers' phrase - quoted earlier) is in fact a way of endorsing conventional values.

This relative account of mental illness is the orthodox psychiatric view in its essentials, and the symptoms listed in psychiatric textbooks are abnormalities, in the sense I have just sketched, of a more or less socially disabling kind. I have argued that such an account of mental illness implies a value-judgement. However, just because the psychiatrist imagines his account to be an 'objective' one, he is unaware of this value-judgement. In a formal sense, therefore, a value-judgement is made; but in a more substantial sense, no moral *judgement* is exercised - that is to say, no moral *thought* is exercised in arriving at this account of mental illness. It is notable in this context that the psychiatric account of mental illness refers only to gross and immediately observable behaviour and is not framed in theoretical terms. That is to say, it assumes that mental pathology is immediately apparent and given as obvious fact. The values implied by the psychiatric account are unconscious and unthought.

I have already made the point that health and illness are practical concepts, necessitated by the project of therapy. When the psychiatric account of these concepts is viewed in relation to its practical context of therapy, then the features to which I have pointed - its relativism, its endorsing of the prevailing social environment and its idea of 'value-free' objectivity - become comprehensible. For the way of *thinking* about mental illness which I have just described is in fact closely related to the *practice* of the individual therapist. [8] People usually (though not always) come to, or are brought to, treatment because they are unable to fulfil their social role. The individual therapist sees the patient only, abstracted from his social context. The therapist, *as* therapist, can act directly on him alone; the social environment from which the patient comes and to which he must return cannot be altered, it must be accepted as a given fact and the demands it makes must be regarded as (in this sense) 'objectively' and unalterably present. From the practical point of view of individual therapy, therefore, the environment is assumed to be 'normal' and illness is considered as individual conditions of abnormality against this background.

The psychiatric account, then, is a purely relative one; it is not based on a psychological or any other theory of human activity but rather presents

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5   Although, n.b., this can provide only the most *minimal* concept of physical health and illness.

6   This point is made at length by Peter Alexander, 'Normality' in *Philosophy,* Vol.48, No.184, April 1973; pp.137-151. However, he fails to see the *ideals* involved in the concepts of mental health and illness, the significance of psychoanalytic work etc etc.

7   Of course it is not suggested, by those who think of mental illness in this way, that *all* deviations from social norms are mental illnesses. For example, the factor of suffering is often mentioned in the attempt to distinguish illness from other forms of deviance; and mental illness is distinguished from physical illness, it is claimed, by virtue of the fact that mental illness is indicated by changes of mental functioning which have no known physical cause. For this sort of argument, see e.g. F Kraupl-Taylor, *Psychopathology*, Butterworths, 1966, Ch.1. Needless to say these lines of demarcation are extremely imprecise at best.

8   I am using this word widely to include medical psychiatrists, although I am aware that their 'therapy' often consists in nothing more than the administration of sedatives and tranquilizers and barely deserves the name.

'mental illness' as a purely individual condition, obvious and immediately apparent against the background of a social environment which is presumed (often unconsciously) to be 'normal'. For all these reasons the psychiatric account has little to offer anyone seriously concerned about the human condition, and it is increasingly being revealed as the rationalization and justification for present social and institutional means for dealing with the problem of 'mental illness'.

An awareness of these points has led to a widespread general scepticism about the concept of mental illness, which has been voiced by philosophers, psychologists and sociologists. [9] Thus, for example, R D Laing writes:

> The 'cause' of 'schizophrenia' is to found by the examination, not of the prospective diagnosis alone, but of the whole social context in which the psychiatric ceremonial is being conducted.
> [10]

Such an investigation reveals, according to Laing, that

> There is no such 'condition' as 'schizophrenia', but the label is a social fact and the social fact a _political event_. This political event, occurring in the civic order of society, imposes definitions and consequences on the labelled person. It is a social prescription that rationalizes a set of social actions whereby the labelled person is annexed by others, who are legally sanctioned, medically empowered, and morally obliged, to become responsible for the person labelled. The person labelled is inaugurated not only into a role, but into a career of patient...
> [11]

Laing thus argues that mental illness is, in Szasz's words, a 'myth'.

The basis for this scepticism is just that relativism, the narrowly practical and technological perspective and the covert conservatism which I have already pointed to in the psychiatric identification of 'illness' with lack of adjustment to the prevailing social environment. This scepticism leads to the total rejection of the concept of mental illness as useful to psychology. Sociologists like Goffman and Scheff [12] in particular, have attempted to show that the behaviour of mental patients can be understood solely in relation to the social institutions in which they exist, without any reference to individual psychological considerations; and Laing, too, has often written as if he accepted this view.

Such scepticism has been polemically aimed at current psychiatric practice, and it has been valuable and illuminating as such. It has led to much critical and important work concerning psychiatric procedures, and it has enabled people to break from the psychiatric attitude - and such a break is nothing less than an essential precondition for a critical and scientific approach to psychology and

to the practical problem of 'mental illness'.

This scepticism has been valuable, then, but its significance is ultimately only _negative_ since in rejecting the concept of mental illness altogether it also implicitly denies the existence of the practical problems of the therapist. To see this it is again necessary to remember that psychiatry is a practical activity as well as a theory, and that the concepts of mental health and illness are _essentially_ practical concepts that define the object and goals of psychiatric practice. The implications of the sceptical rejection of the concept of mental illness are, therefore, that the practical problems tackled by therapy are unreal ones and that the project of therapy should be abandoned.

To this, the psychiatrist will reply [13], surely with justification, that _there is_ suffering of a non-physical kind which the concept of mental illness is supposed to describe and which is _real_ suffering that cannot be ignored for philosophical niceties. The sceptical approach simply rejects orthodox psychiatric thought and practice; but in doing so, it entirely forgets the _practical need_ for psychiatry: the real suffering and misery to which psychiatry is intended to be a response. This real suffering is the phenomenon which the concept of mental illness is supposed to describe and specify. In tackling the _practical problems_ which this suffering presents, the therapist is, or at least ought to be, helped and guided by a theory. And for the theory to fulfil this practical task, it must portray such suffering as illness, over against health as a value.

The values of health and illness are the embodiment of the ideals of therapy, which are those of medicine: the relief of suffering, the healing of sickness. None of the arguments of the scepticism I have been discussing actually dispute these ideals. What this scepticism _does_ argue is that this suffering has been conceived wrongly by psychiatric theory and that orthodox psychiatric therapy does little or nothing to relieve and heal it. But because this scepticism is merely negative towards the concept of mental illness, it ends up by denying these ideals altogether, without giving any argument.

Whereas the psychiatric account asserts these ideals blindly in an uncritical and mystified form, this scepticism denies them equally blindly. Both represent a failure to think through the practical problem in critical and theoretical terms; and that is to say, both represent a failure of serious moral and psychological thought.

In the remainder of this paper my main purpose will be to argue that psychoanalytic thought offers the basis of an alternative account of the phenomenon of 'mental illness' which is (at least potentially) critical of the psychiatric account [14] and yet not totally sceptical and in terms of which the practical (i.e. moral and social) problems of 'mental illness' may more adequately be seen and discussed.

II

The significance of the contribution of psychoanalysis to the understanding of mental illness and mental health, and its significance for moral and

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9 e.g. T S Szasz; R D Laing and his ex-co-workers; E Goffman and T J Scheff, and also Sartre's critique implicit in _Being and Nothingness_, Part I, Ch.2, 'Bad Faith'.

10 R D Laing, _The Politics of Experience_, Penguin Books, 1967, p.86.

11 _Ibid._, p.100.

12 E. Goffman, _Asylums_, Penguin Books, 1968; and T. J. Scheff, _Being Mentally Ill_, Weidenfeld and Nicolson, London, 1966. See also the recent and dramatic work of D. L. Rosenhan, 'On Being Sane in Insane Places', _Science_, Vol.179, 19 January 1973, pp.250-8.

13 See e.g. H. J. Eysenck, in his reply to Laing, 'The Ethics of Psychotherapy', _Question 3_, January 1970, esp. p.3.

14 The qualification is important. The psychoanalytic movement has reached a _modus vivendi_ with psychiatry, a division of labour in this area. The effect of this at the _theoretical_ level has been that psychoanalysts have not tended to develop the critical implications of their theory towards orthodox medical psychiatry.

social thought are not well understood in this country, particularly among moral philosophers. This is partly because the positivistic tenor of so much recent British philosophy has systematically blinded it to what might be of value, not only in psycho-analysis, but in all social thought and moral thought. It is hardly an exaggeration to say that the domin-ant tradition of moral philosophy in Britain has made no concrete contribution to moral thought - and what is even worse, it has not attempted to do so, but has abdicated the task of substantial and *conscious* moral thought (it is, of course, a substantial moral ideology, but it is so *unconsciously*).

Thus it is not surprising that even where the moral significance of psychoanalysis has been discussed by these philosophers it has been mis-understood and misdescribed. For example, it is often thought that psychoanalytic theory is a theory only about 'pathological' or 'abnormal' behaviour, and that its moral significance is confined to the redefinition of our attitude to such behaviour. This is only a fragment, and a relatively minor one, of the truth.

An understanding of psychoanalytic thought does, of course, alter one's attitude towards the 'patho-logical'; but in so doing, it has profound and far-reaching implications for one's concept of 'the normal'. And it is in its relations about 'normal' everyday life that psychoanalysis has its major moral significance. Laing is particularly clear on this:

> The relevance of Freud to our time is largely
> his insight and, to a very considerable extent,
> his demonstration that the ordinary person is
> a shrivelled, desiccated fragment of what a
> person can be. [15]

Nevertheless, Freud did arrive at his psychological conclusions through his investigation of mental illness, and it was implicit in the theoretical understanding of mental pathology which he evolved. A very brief review of the history of Freud's discoveries may help to make this clear, and also to emphasise that Freud did not arrive at this sort of conclusion speculatively or by any form of merely abstract reasoning.

Freud was trained as a doctor, and he accepted from this training the psychiatric and relative view of mental illness which I described earlier. His first patients were hysterics: that is to say, patients with *physical* complaints, gross and obvious symptoms which more or less incapacitated them in their everyday lives. At the very outset of his psychiatric career, Freud proceeded in the psychiatric manner, to attempt to *eradicate* these symptoms. Freud used hypnosis for this purpose, and (in the initial cases reported in his first major psychological work, *Studies on Hysteria*) he describes how he would attempt to command the disappearance of the patient's symptoms while the patient was hypnotized. This method of treatment - literally ordering the symptoms to disappear - is still used by some psychiatrists today. However, Freud was not satisfied with this procedure; his objections to it were both theoretical and practical. Such a purely symptomatic treatment offended against his very clear vision of proper scientific procedure in medicine; it was a purely pragmatic treatment which lacked a basis of theoreti-cal understanding and justification. But furthermore, judged by pragmatic criteria, it was ultimately ineffective, as he learned from the case of Miss Lucy R.:

> What had happened was precisely what is always
> brought up against purely symptomatic treatment:
> I had removed one symptom only for its place to
> be taken by another. [16]

15 R D Laing, *The Politics of Experience*, p.22.

16 Freud, *Studies on Hysteria*, Standard Edition
    Vol.2, p.119.

What set Freud on the path to psychoanalysis was his hearing about a case treated by his colleague and friend, Breuer - the case of Anna O. Breuer had found that when she remembered and communicated certain events associated in her mind with her symp-toms, an alleviation of her symptoms ensued. Freud became interested in this case and tried applying its method in his own work. He was not a good hypnotist and quickly abandoned the use of it when he discovered that he could get his patients to recall the relevant material without its help.

These memories and associations, however, were not immediately present in his patients' consciousness; they had to be extracted against the resistance of the patient. The observation of this *resistance* the patient's part led Freud to the idea that such *unconscious* ideas (which were highly charged emotion-ally) are actually kept out of consciousness by a force, which he called *repression*. Freud also observed that when he asked the patient what he remembered in connection with the first onset of his symptom, the patient would sometimes say he could remember nothing and that nothing occurred to him. However, on pressing it would transpire that something *had* passed through the patient's mind, but that he had deemed it irrelevant and had not mentioned it. As a result of his investigations, Freud came to the conclusion that such apparently irrelevant ideas ('free associations') in fact occurred for a reason, and that by trying to discover this reason he was in fact pursuing his investigation of the nature of the symptom; and that he could get the patient to recognize and possibly even reconcile himself with the repressed and unconscious ideas and desires which were at the root of the symptom (its hidden nature, its 'latent content'). [17] Furthermore, Freud discovered that these repressed ideas and desires were commonly sexual, often of the most tabooed form, and had a continuous history stretching back to earliest infancy.

In this way, and gradually over a long period of time, Freud came to a theoretical understanding of the nature of neurotic symptoms. According to this theory, neurotic symptoms arise from a conflict bet-ween a person's libidinal and pre-social instincts and opposing repressive forces within the personality, particularly the dictates of morality and conscience. Although the idea of a conflict between desire and morality was a common one before Freud, what Freud showed was that if this conflict becomes too intense and anxiety-provoking, the desire, the instinct, is repressed - put out of mind and inhibited from active expression. This is not the end of the story, however, for the repression of the instinct does not abolish it. It continues, as Freud puts it, 'to press for satisfaction', which it achieves (in a compromise form) in *thought* in the form of fantasy and in *action* in the form of (neurotic) symptoms.

This theory of neurosis not only altered Freud's understanding of, and therefore attitude to, 'mental illness', it also changed his attitude to normality. For the explanation which Freud had developed of the psychiatric symptoms of hysteria applied equally to a very extensive range of absolutely normal behaviour. What Freud discovered was that a great deal of 'normal' behaviour in fact had exactly the same structure as did neurotic symptoms. Again he dis-covered this through his analytic practice. For example, he noticed that his patients frequently and spontaneously recounted their dreams to him for no apparent reason, as 'free associations'. Instead of brushing these aside as irrelevant to the treatment, Freud investigated them, and this investigation led to his richest work, *The Interpretation of Dreams*.

Freud's theory of dreams portrays them as having *exactly* the same structure of repression and compro-

17 Freud describes his initial discovery of these
    facts in his account of 'The Case of Elizabeth
    von R.' in *Studies on Hysteria*.

mise and wish-fulfilment as do neurotic symptoms. And in addition to dreams, Freud argued that many other absolutely 'normal' phenomena, like symptomatic errors and slips of the tongue, certain very common patterns of relationship which he called 'transference' and also traits of character, compulsive moralizing and 'the fear of God', had the structure of neurotic symptoms.

Although, as I shall go into later, Freud did not follow the implications of this theory through to their end, this psychoanalytic account of neurotic symptoms ultimately implies an approach to the problems of mental illness which is distinct from and in contradiction to the orthodox psychiatric account. On the basis of this psychoanalytic theory it seems that what is characteristically *pathological* about a mental sympton (i.e. what makes behaviour symptomatic) is that it involves *repression*. [18] Mental pathology is thus thought of as *division* within the personality, and health is conceived as the unity, integrity or wholeness of the person and the absence of wasteful energy consuming self-division and self-alienation. When the implications of psychoanalytic theory for the concepts of mental health and illness are interpreted in this way, the goal of psychoanalytic practice is (in theory at least) to *heal* the mind and person, in the original sense of 'to heal' which is 'to make-whole, to make-one'. Some of the formulations which Freud gives of the aim of analysis emphasise this idea of health as unity the corresponding healing function of psychoanalysis. For example, he writes:

> The aim of our efforts may be expressed in various formulas - making conscious the un-conscious, removing the repressions, filling in the gaps in memory, they all amount to the same thing. [19]

It is clear that this represents a very different way of thinking about the concept of mental illness to the orthodox psychiatric account which I described earlier. First of all, the concepts of mental health and illness are now absolute and not socially relative concepts. Mental illness is thought of as an individual condition the distinguishing criteria of which do not refer to the prevailing social environment, but only to psychological processes within the individual. This absolute account of mental illness does not therefore make the prevailing environment into the criterion of normality and health.

On the contrary: the absolute account of mental illness is founded on an account of the function of a person which is in conflict with that assumed by the psychiatric account. I have already described how the psychiatric account maintains that the function of a person is to fulfil his basic role as a member of society. The absolute account considers the function of a person abstractly in-itself, and not in relation to his particular social role. The function of a person is thus thought of in terms of self-realization as an integral person, lack of alienation and wasteful self-repression, satisfaction of his basic human nature (i.e. instincts), happiness etc. And it is clear from what Freud writes that the functions which these two accounts each suggest are conflicting ones. In present conditions at least, the social environment requires the individual to

repress a lot of his desires. And so the sort of absolute definition of mental illness which is suggested by psychoanalytic theory, so far from making the social environment the criterion of health, tends to be critical of prevailing social conditions in the name of health. Repression and therefore neurosis are absolutely normal and universal features of our present lives.

As Freud says:

> It is impossible to overlook the extent to which civilization is built up upon a renunciation of instinct; how much it presupposes precisely the non-satisfaction (by suppression, repression or some other means?) of powerful instincts. This 'cultural frustration' dominates the large field of social relationships between human beings. [20]

The state of 'normality', which is the assumed standard of health in the psychiatric account, is revealed by this view as one of unconsciousness, alienation and neurosis. Laing puts this view force-fully when he writes:

> As adults, we have forgotten most of our childhood, not only its content but its flavour; as men of the world we hardly know of the exitence of the inner world; we barely remember our dreams, and make little sense of them when we do; as for our bodies, we retain just sufficient proprioceptive sensations to coordinate our movements and ensure the minimal requirements for biosocial survival - to register fatigue, signals for food, sex, defaecation, sleep; beyond that, little or nothing.
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> The conditions of alienation, of being asleep, of being unconscious, of being out of one's mind, is the condition of the normal man. [21]

The standards of health and illness are here applied according to criteria which are absolute: which transcend the particular social envirionment of the individual and which appeal to absolute values. These criteria are not the result of direct and immediate observation, but are the product of the attempt to comprehend the phenomenon of normal and abnormal behaviour theoretically. Furthermore, because they suggest that everyone is 'ill', their practical implications for therapy are idealistic.

Freud himself, however, never endorsed the absolute account I have just outlined (even though it is implicit in his theory), nor did he ultimately acknowledge the ideals of health of the absolute account nor its practical implications. This is not to say that the practical implications of psycho-analytic theory were entirely ignored by Freud in his work. Freud's therapeutic work, in fact, did change considerably in character with the develop-ment of his theoretical understanding as Reiff observes:

> In the beginning ... though the patients Freud treated did disclose doubts about what to do with their lives ..., there were always tangible symptoms - a paralyzed leg, a handwashing compulsion, impotence - by the resolution of which one could certify the cure ... [but later] all experience is symptomatic... People seek treatment because they sleep poorly, or have headaches, or feel apathetic towards

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18 More accurately, a symptom according to Freud involves 'the return of the repressed' desire. But the repressed wish always 'returns' and gains expression, even if only in dream and fantasy. These assertions need further discussion which I cannot give here.

19 Freud, *Introductory Lectures on Psycho-Analysis*, trans. Joan Riviere, Allen & Unwin, 2nd Ed., 1929, p.363.

20 Freud, *Civilization and its Discontents*, Hogarth Press, revised ed., 1963, p.34.

21 R D Laing, *The Politics of Experience*, pp.22-3.

loved ones, or because they are dissatisfied with their lives. [22]

Nevertheless, as I have argued already, psychoanalytic theory implies that a vastly more extensive range of phenomena are pathological than this. However, in practice, patients do not come wishing to be cured of such 'normal' neuroses, unless they are causing them impairment in their everyday lives.

Freud is ultimately unwilling to divorce the concepts of health and illness from the context of therapy, and it is for purely *practical* reasons, connected with therapy, that Freud is unwilling to abandon the psychiatric and relative account of mental illness, no matter how much it conflicts with his psychoanalytic theory. Thus he says, for example:

> *The healthyman ... is virtually a neurotic, but the only symptom he seems capable of developing is a dream. To be sure when you subject his waking life to a critical investigation you discover something that contradicts this specious conclusion; for this apparently healthylife is pervaded by innumerable trivial and practically unimportant symptom-formations.*
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> *The difference between nervous health and nervous illness (neurosis) is narrowed down therefore to a practical distinction, and is determined by the practical result - how far the person concerned remains capable of a sufficient degree of capacity for enjoyment and active achievement.* [23]

In other words, according to psychoanalytic theory everyone has neurotic *symptoms*, but it does not follow that everyone is *neurotic* because the concept of illness (unlike that of symptom) is a practical and not a theoretical one. What Freud means by 'practical' here is shown in the following passage, where he considers the question of whether everyone might be neurotic. He writes:

> *May we not be justified in reaching the diagnosis that, under the influence of cultural forces, some civilizations, or some epochs of civilization - possibly the whole of mankind - have become 'neurotic'? ... ·As regards the therapeutic application of our knowledge, what would be the use of the most correct analysis of social neuroses, since no one possesses authority to impose such a therapy upon the group?* [24]

What Freud is saying here is that from the point of view of individual therapy, the absolute account of mental illness and health is an impractical and utopian one. And it is for this reason that he retains the psychiatric and relative account as well.

Freud thus tries to hold on to both the psychiatric account and the psychoanalytic theory of neurosis at the same time - but these two are in contradiction. Freud never properly appreciated this contradiction in his thought, and he tended to ignore the implications of psychoanalytic theory and to dismiss them on the narrowly practical grounds of the possibility of individual therapy when they came to his attention. [25]

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22 P. Reiff, *Freud: The Mind of the Moralist*, Methuen, 1965, p.304.

23 Freud, *Introductory Lectures*, p.382.

24 Freud, *Civilization and its Discontents*, p.81.

25 He had other more sophisticated, although purely speculative, ways of dealing with this contradiction as well; e.g. his talk of 'qualities of psychic energy bound in repression. To discuss this matter adequately here would, however, take me too far away from my central purpose, and I will have to return to it elsewhere.

Freud's account of mental health and illness is contradictory, therefore, since it contains (implicitly at least) both the accounts of these concepts which I have outlined: the relative and the absolute.

In conclusion now I want to argue that this contradiction in Freud's thought has an important significance, and that we can learn from it; and that it should not simply be dismissed as a sign of mere confusion, as many contemporary British philosophers are inclined to do when they come upon contradictions. For there are *reasons* for Freud's thought being contradictory on this matter, there are *reasons* for asserting both of these contradictory accounts.

Earlier I argued that there is a real basis to the psychiatric account in the real problems that confront the psychiatrist in his practice; and I have also tried to show that the account of mental illness given by psychoanalytic theory is a well founded one. Both of these conclusions need to be incorporated in an adequate account of mental illness, and yet they seem to be opposed. For the struggle between the social values of conformity embodied in the psychiatric account and the apparently individual values of fulfilment expressed through psychoanalytic theory is a real one. [26]

Freud, when he did not just ignore it, thought that this conflict was an eternal one, and in the nature of things. His pessimism is notorious: he did not believe that the individual can achieve fulfilment; neurosis, and the frustration it involves, were for Freud, inevitable. And he saw no alternative to a familiar and very real dilemma: either you are spontaneously free and unrepressed, in which case your society will suppress you; or you repress yourself and comply with the demands society makes upon you.

But these are not the exclusive alternatives; and the belief that they are, it seems to me, derives from the fact that ultimately Freud adopted the individualistic perspective of the therapist - the psychiatric account of mental illness, which accepts the social environment as fixed and given. However, Freud's theory suggests that the social environment itself may be pathological. The practical implication which Freud drew from this was that a therapist is needed with the authority to treat society as a whole. This is hardly practical, but surely a more realistic conclusion would be that social and not merely individual change is necessary if the therapeutic project of eliminating illness and promoting health is to be achieved. What psychoanalysis reveals is the social and ultimately political content in the concepts of mental health and illness.

The problem of mental illness, then, is a social and a political problem, but it is not *just* a social or political problem it is also an immediate individual problem, and this is stressed by the psychiatric account and must not be forgotten either. The problem of mental illness does not initially and immediately arise as a social one. Immediately and initially it confronts the practising psychiatrist as an individual problem, in the shape of individual patients who are suffering and need help. This immediate problem is a real one, and people need the kind of help which psychiatry is supposed, but in fact too seldom does, provide. To *simply* say: the problem is really a political one and will be solved only when a revolutionary social change has abolished the family,

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26 I have used Freud's dichotomy between social/ individual here, but I think it must be critically rethought (along with other aspects of Freud's ideas on human nature and society) if the contradiction in Freud's thought which I am discussing is to be resolved satisfactorily.

exploitative work and the other alienating features of our society - to say just this is to ignore the immediate practical problem which confronts the psychiatrist.

The immediate problem requires action, and it is only through the attempt to deal with this immediate problem, both practically and theoretically, that its social and political dimension is revealed. In other words, the problem is *both* individual and social; and each of the accounts I have described in some way ignores this.

Psychiatry must be a twofold activity which acts at an individual and at a social level. The psychiatrist must help the individual as he can, and also fight those alienating and repressive social and psychiatric institutions which frustrate this work. The concepts of mental health and illness (or their equivalents), critically and theoretically developed, are valuable in guiding this task; and it is possible to reject the blinkered conservatism of psychiatry without ending in a total scepticism which has the effect of ignoring the real problems. Perhaps the concept of mental illness is too tainted by its psychiatric use to be anything but misleading for these purposes. The concept of alienation is a [27] natural alternative, but unfortunately it has lost almost all precise meaning through over-use in recent years. Despite this, however, the concept of alienation has the advantage of suggesting a *social* aspect to the condition it describes; and in addition to this it has close historical associations with the concept of mental illness in the 19th century ('alienism' was a common word for psychiatry). But most importantly, the term 'alienation' has evaluative implications, and the use of it involves the recogni-

tion that such states, no matter how 'normal', are states of suffering and ought to be a cause for concern.

The concepts of mental illness and alienation are moral concepts. Indeed they are among the most important categories of contemporary moral thought; but not in the sense of 'morality' in which many contemporary British philosophers, to judge from their examples ('He ought to do *X*', '*Y* is right', '*Z* is good' etc) appear to understand the term. 'Mental illness', as I have tried to show, is not a *merely evaluative* concept: it is always embedded in a 'theory' - a more or less systematically organized point of view - by means of which man and his activity are understood and assessed. The discussion of this concept by recent British philosophers has, however, often quite deliberately excluded any critical consideration of psychology, social theory etc. etc., with the result that it has tended to uncritically endorse conventional attitudes by reporting 'ordinary usage'. This is a sure recipe for producing ignorant apologetics. Anyone with a faith in the possibility of philosophy being used as a weapon of criticism (i.e. a radical philosophy) will see the need to expose such ideological philosophy and replace it. For this, a concern with psychology and social theory is essential. This is not something 'in addition' to moral philosophy but rather one of its essential aspects.

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27   It has been used in this way by R D Laing in
     The Politics of Experience. See also J. Gabel,
     La Fausse Conscience, Editions de Minuit, Paris,
     1962.

THIS KID HAD STARTED WITH HIS HEAD
FULL OF THE USUAL SHIT ABOUT ALIENATION
'CLASS DICTATORSHIP' AND 'OPPRESSION'.
THE DOC PULVERISED HIM RIGHT IN FRONT
OF THE CLASS WITH THE OLD PARADIGM CASE
ONE-TWO FOLLOWED UP WITH THE CRITERIA
CRUNCH AND A QUICK ANALYTIC-SYNTHETIC
COMBINATION TO THE HEAD. . . . .

HEY, THAT'S GOOD! HOW'D YOU DO IT?

DO SOME MORE!

IF ONLY I COULD MAKE HIM TELL ME HOW HE DOES IT...

WHEW!

THEY SAY HE'S CHANGED SINCE THOSE DAYS,
THAT HE'S LEARNING THE ROPES AND
GETTING INTO PROBABILITY THEORY ...

"The universities are the fountains of the civil & moral doctrine, from whence the preachers & the gentry ... sprinkle the same upon the people" (Hobbes).

"As in religion we are warned to show our faith by our works, so in philosophy by the same rule the system should be judged by its fruits, and pronounced frivolous if it be barren, more especially if, in place of fruits of grape and olive, it bears thorns and briars of dispute and contention."(Bacon)

University news

Professor of Peace to be appointed

A professor of peace, believed to be the world's first, is to be appointed shortly. The Senate of Bradford University are completing details for the appointment and it is hoped the new professor will start work next autumn. The chair in peace studies is being established with the help of a £75,000 grant from the Society of Friends, which was raised in only nine weeks.

The pro vice-chancellor of the university, Mr Robert McKinlay, said that the new department would investigate the causes of conflict, also the reasons for reaching agreements. It would cover international conflict and would probably investigate industrial strife and race relations.

Oxford
St Hugh's College : Miss Trickett, fell tutor in elected

No news has yet been received of plans for a Professor of Class Struggle.