CHAPTER IV

Szasz’s Views and Differences

Section I

General Comments

In chapter IV we summarized Szasz’s views against psychiatry or, more specifically, psychiatry’s effort to construe odd or disturbing experience and behavior as mental illness as:

--- illness is a physical phenomenon; only a bodily organ can become diseased

--- mind is not a bodily organ

--- there is no physical component in ‘mental illness’

--- ‘mental illnesses’ are essentially social and ethical value judgments

--- there is nothing called mental illness

In this chapter we shall discuss Szasz’s views and opinions and shall try to build up counter-arguments against these views. We shall try to understand:

(i) Is disease really only a bodily entity? Do we really conceptualize disease as involving only the anatomical or physiological level?
(ii) Is disease really a value-free, objective, scientific description of pathology at anatomical and/or physiological level?

(iii) Are the putative ‘mental illnesses’ just moral/ethical judgments?

(iv) Can we build up arguments that will counteract the above views and that can support psychiatry’s claim that these odd and disturbing behaviors we call madness can be understood as mental illness and can be object of study by science?

In the last few decades, after Szasz came out with his critiques of psychiatry, many scholars have engaged in this discussion. In our effort to deal with the above given questions, we shall discuss the contributions of these authors and to built up our understanding of disease as a concept we shall borrow the insights of Georges Canguilhem. To set the tune of discussion, we start our discussion from an article by, a renowned psychiatrist who, apart from his seminal contributions in psychiatric genetics, had a deep interest in the philosophical issues related to psychiatry and tried to put psychiatry on a sound philosophic foundation.

Kenneth S. Kendler, in his 2005 article “Towards a Philosophical Structure for Psychiatry” gives his first proposition for such framework as “Psychiatry is irrevocably grounded in mental, first-person experiences.” He goes on to add: “The questions that have played such a prominent role in the history of psychology --- whether mental processes can or ought to be studied ---- are simply not relevant to psychiatry. Our central goal as a medical discipline is the alleviation of the human suffering that results from dysfunctional alterations in certain domains of first-person, subjective experience, such as mood, perception, and cognition.” (Kendler, 2005 p. 433) Kendler indicates the path to achieve this goal through rejection of Cartesian mind-body dualism, rejection of the view of ‘mind’ as an epiphenomenon arising out of material world, acceptance of bidirectional mind \(\rightarrow\) body and body \(\rightarrow\) mind causality and acceptance of explanatory pluralism.

Kendler shows great perspicacity in grounding psychiatry in subjective, first-person experiences and, in doing so, focusing this grounding as the source of problems of the philosophical structure
of psychiatry. At the same time, one cannot but feel a little amused at how easily Kendler brushes aside the fundamental problems as ‘not relevant to psychiatry’ and starts his discussion with simple and unquestioned acceptance of psychiatry as a medical discipline. In the year 2005, when this was written, it probably appears to be a fait accompli that psychiatry is a medical discipline judging by its worldwide spread, acceptance by general public, inclusion in governmental policy and planning and the burgeoning industry of psychopharmacology. Notwithstanding these, some fundamental philosophical problems still remain vexing and unsolved. Simply stated, the problem is: how can the subjective first-person experiences of one become accessible for objective scientific study by another? Does not such an attempt entail a normative (and potentially biased) value judgment by one on the other? Can such value judgments be reconciled scientific objectivity?

These questions formed a large part of the antipsychiatric criticism of psychiatry and the most clear and concise formulation of these criticism are to be found in the works of Thomas Szasz though Szasz did not consider himself to be associated with or as a part of the antipsychiatry movement. We have given an account of Szasz’s views in Chapter I and have given the basic arguments at the beginning of this chapter. We shall now look at Szasz’s arguments and the counter-arguments offered by different scholars. We shall also try to reach our own views of these arguments and counter-arguments but before these, as a foundational work for this chapter, we shall look at the work of another author and philosopher, Georges Canguilhem. From Canguilhem we shall try to derive insights about the concepts abnormal, pathological, disease etc as they apply to medical science.
Section II

Georges Canguilhem and the Theory of the Pathological

Georges Canguilhem (1904 –1995) was a French doctor and philosopher who specialized in epistemology of science and, in particular, of biology. Canguilhem is relatively less well-known in the English speaking word as a philosopher of science though Arthur Goldhammer perceived Canguilhem as a precursor of Paul Feyerabend in Against Method. (Goldhammer, 1996) Canguilhem’s first major work Le normal et le pathologique, his doctoral dissertation, was written in 1943. This was revised and had a new section added in the second edition of 1968. The English translation, The Normal and the Pathological, first appeared in 1978 and the second edition came out in 1991. The importance of the book can best be described by quoting Roy Porter who wrote a review of it in the London Review of Books: "When is a disease not a disease? ... Is it valid to talk of a person being ill without a disease or having a disease without being sick? All these problems—of definition, demarcation and decision—we feel are special to medicine today. It is chastening, therefore, to be reminded that the questions underlying them were being analyzed, with great perspicacity, by the French philosopher and historian of science, Georges Canguilhem, in a work written in 1943 and now gratifyingly back in print in an English translation." (quoted in Canguilhem, 1978) Michelle Foucault wrote the introduction English edition of Normal and the Pathological, and there he hailed Canguilhem as his own mentor and precursor. In the same article Foucault distinguished between two schools of French epistemology that developed in the middle of last century, "philosophy of experience, sense, and subject" (represented by Sartre, Marleau-Ponty and such others) and "the philosophy of knowledge, rationality, and concept" and called Canguilhem the founder of the second, bringing in and carrying on the Heideggerian method and tradition.

Canguilhem as a historian and philosopher of science is not our focal concern here but his idea of the pathological is. Even then we need to note an important point about Georges Canguilhem. Most other philosophers of science deal with physics (and chemistry to a lesser extent) taking it as the paradigmatic science. Choosing biology and medicine as his focus, Canguilhem, on the one hand deprived himself of the rich historical resources of Copernican revolution, Galilean methods and Newtonian mechanics and the many achievements of twentieth century physics.
and, on the other hand, brings upon himself the task of defining the field and method of biology. Canguilhem achieves this task by defining ‘concept formation’ as the starting point of biology. Foucault, in his introduction to *The Normal and the Pathological*, wrote: “Canguilhem would undoubtedly allow one to say that the moment which must be considered strategically decisive in a history of physics is that of the formalization and constitution of the theory; but the moment that counts in a history of biological sciences is that of the constitution of the object and the formation of a concept.” (Canguilhem, 1978. p.20) Canguilhem also insists upon the separation of concepts from any theories which may “use” those concepts. Concepts are not embedded in theories, and they do not derive their meaning from the associated theories. Instead, concepts permit one to identify data in a scientifically meaningful and useful manner; theories explain the data and/or phenomena identified by concepts prior to their explanation by theories. Concepts permit scientific questions to be formulated and theory provides scientific answers to those questions. Concepts are also claimed to be ‘theoretically polyvalent’ (Canguilhem, 1988). Canguilhem believes that there is a close relationship between concepts and what we understand as biological phenomena. Though he rejected the distinction often assumed between (neutral) facts and theories, he did not do so in any simplistic fashion which claims that there are no observed facts apart from their theoretical interpretations. His position is much more complex and he makes distinctions between the terms, concepts and theories. Concepts identify phenomena as biological entities, not theories in biology. Theories explain those phenomena identified, prior to any explanation, by concepts. What Canguilhem studied is the formation of concepts in biology because the function of a biological concept is to cut out, from the ensemble of the phenomena of life, the entity which allows one to analyze the process central to living beings. Let us take an example to understand Canguilhem clearly. Consider the entity or process of photosynthesis. Study of photosynthesis as a biological process does not end in detailed description of the series of chemical reactions only but has to include ideas about these reactions (or the whole process) as being beneficial to plant life. There is a difference between photosynthesis studied as a simple chemical process and photosynthesis studied as a complex biological process. In the later case, photosynthesis needs to be first conceived as a process beneficial to plant life where ‘beneficial’ and ‘life’ are both not entities given in the natural world but value-based concepts. There cannot be an object pertinent to enquiry by biological science unless it has been first conceived in this way. This act of ‘conceiving’ occurs in the
context of the totality of the interaction between a living organism and its environment and not through some isolated and isolating external observation. Activity of biological sciences is inexorably related to a particular way of looking at and understanding life ----- a view very much structured by and construed within the human conceptual architecture.

In *The Normal and the Pathological* Canguilhem starts by analyzing the way in which health and disease were being defined in the early 19th-century, showing that the emerging categories of the normal and the pathological were far from being objective scientific concepts. He starts with the then prevalent Auguste Comte’s positivistic ideas and goes on to discuss the ideas and works of various physicians and physiologists. The prevalent view at that time (and this is largely so even today) was that the abnormal or pathological was simply a deviation from a given biological (anatomical and/or physiological) norm and this norm is statistically derivable in a given population. He attacked the notion that the concepts of the normal and the pathological, so essential to the thought and activity of medicine, could be interpreted in such a straightforward positivistic and statistical manner. He attacked the fundamental notion that normal is a statistical mode or mean, because that means conceiving and treating a living system as structured and governed in a law like manner. If that were the case it would have always been in a pre-established and pre-arranged harmony with the environment. Instead, Canguilhem argued, the human organism, nay all biological organisms, is a living, vital and continuously changing one which is by no means in any pre-established harmony with its environment but continuously trying to forge such a harmony. As Canguilhem said, the laws of Galilean or Cartesian mechanics cannot by themselves explain the origin of coordinated organ systems, and such coordinated systems are precisely what one means by ‘life’. The whole argument of the first part or the original part, of *The Normal and the Pathological* is directed against Claude Bernard’s conception of science and its method. That argument culminates in this lapidary formulation: "...it is first and foremost because men feel sick that a medicine exists. It is only secondarily that men know, because medicine exists, in what way they are sick." (Canguilhem, 1978. p.229) Canguilhem wrote: "When one knows that the word ‘norma’ is Latin for ‘carpenter’s square’ and that ‘normalis’ means ‘perpendicular,’ one knows almost all there is to know about the realm in which the meanings of the terms norm and normal originate, and from which those terms were imported into a wide variety of other realms." (Canguilhem, 1978. p.239) This recourse to the
etymology of a common word from an ancient language, in order to give an everyday abstract concept new insight is similar to the practice of Martin Heidegger. The concepts of normality and the norm are at the centre of Canguilhem’s work. He saw the history of medicine as a continual swing between value-free descriptive activity and normative judgments. Emergence of experimental methods in medicine led to laboratory and animal-based research methods that supplanted purely descriptive traditions. Results here are now meaningful only if they support cause and effect (normative) assumptions. A morbid condition of the body or mind that has identifiable and describable symptoms and signs, together with a discernible natural history in the context of cells, organs, individuals, and populations comes to be defined as a disease. But for Canguilhem, the normal begins instead with the living organism in interaction with its environment and having an order of specific properties. He argued that medical practice must be based upon the diversity of life form and this in turn provides the paths for its own conceptualization and for the restoration of its normal state. “To say that ‘no doctor proposes to produce a new kind of man, with a new arrangement of eyes or limbs’, is to recognize that an organism’s norm of life is furnished by the organism itself, contained in its existence” (Canguilhem, 1978. p.159). Canguilhem views normality as the ability to adapt to the changing circumstances, to environments which are varied. It thus involves activity and flexibility on the part of the organism so that the living being lives in shifting relationships with a continuously changing environment. Medical dictionaries define the normal as ‘that which conforms to the rule, regular’. Canguilhem extends this brief definition as follows: ”(1) normal is that which is such that it ought to be; (2) normal, in the most usual sense of the word, is that which is met in the majority of cases of a determined kind, or that which constitutes either the average or standard of a measurable characteristic” (Canguilhem, 1978. p.125). “There is no sense of a pathological normal for living organisms and hence there can be no purely objective pathology”. (Delaporte, 1994). Canguilhem derives his ideas primarily from Leriche and quotes him: “Health is life lived in the silence of the organs [and] disease is what irritates men in the normal course of their lives and work, and above all, what makes them suffer.” (Canguilhem, 1978. p.91)

Canguilhem’s thesis on life can be stated as:

- life is an irreducible concept and one which is necessary to science;
• its content is given through experience as living beings as well as our observation of living beings;
• our conceptual activity in general is a continuation and extension of our existence as living beings. (Delaporte, 1994)

Canguilhem was concerned with disease and pathology in general, in a physical sense, and was not particularly interested in psychopathology and mental illness though he included them in his idea of disease and pathology. At least once, within the discourse of the book, Canguilhem quotes Minkowski to disagree with him on this point. Minkowski maintained that the fact of insanity cannot be reduced to just the one fact of disease.\(^{31}\) “The individual dominates the sphere of mental deviations much more than he does in the somatic sphere.” (Minkowski, quoted by Canguilhem, 1978. p.118) Canguilhem maintained a different view that allowed a medical view of madness but it is a part of Canguilhem’s view of health and disease, physiology and pathology in general and that is important to us here. As he puts it, “…. is the concept of disease a concept of an objective reality accessible to quantitative scientific knowledge? Is the difference in value, which the living being establishes between his normal life and his pathological life, an illusory appearance which the scientist has the legitimate obligation to deny?” (Canguilhem, 1978. p.76)

Canguilhem’s answers to both questions are in the negative. It is the living being’s experience of altered life, difficulty and distress that defines the abnormal, the disease and the pathology. Concept of illness arises from a negative judgment of a lived experience of a subject. There are situations where the individual is feeling perfectly healthy but a doctor is diagnosing pathology. Findings of high blood pressure or high blood sugar levels often occur during routine checkups. This comes about because accumulated medical experience tells us that presence of these conditions, like high blood pressure or high blood sugar levels, strongly predict occurrence of certain illnesses in near future. These illnesses were primarily identified through negative lived-in experiences. In fact, the practice of routine medical checkup rests on the evidence that these predictabilities constitute a real threat to the future health and wellbeing of the individual. Conceptions of disease, illness and pathology are thus primarily normative concepts arising out of the subjective experiences of living beings in the totality of their lives and these entities are

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\(^{31}\) Of course the argument does not amount to denying the possibility of viewing insanity as disease; it only means such a view does not fully explain the phenomenon of insanity or exhaust all the possible meanings of insanity and piecemeal or partial explanations are not logically unacceptable.
objects of scientific study only secondarily. These values and norms are vital or biological values and norms; these judgments are not social or ethical judgments. Biological laws derive from laws of physics and chemistry but biological norms derive from lived experience. The laws of physics and chemistry do not differ in health and illness; only biological values differ. “….the states of an organism are like those found in music: the laws of acoustics are not broken in cacophony ---- this does not mean that all combinations of sounds are agreeable. ….. Life itself introduces the categories of health and disease into human consciousness. These categories are biologically technical and subjective, not biologically scientific and objective. ….. Strictly speaking then, there is no biological science of the normal. There is a science of biological situations and conditions called normal.” (Canguilhem, 1978. p.228 [italics in the original text])

Normality and health are functional characteristics of the whole organism. Health is the ability of the organism to adapt to challenges posed by the environment, to create new norms for new settings. Environment defines one's state of health or disease through one's adaptability. An inability to tolerate and adapt to one's environment produces disease “The patient is sick because he can admit of only one norm. To use an expression which has already been very useful to us, the sick man is not abnormal because of the absence of a norm but because of his incapacity to be normative.” (Canguilhem, 1978. p.186)

We should, in view of our previous discussion on Jaspers, mention that Canguilhem recognized Jaspers as fundamentally supporting his views on medical approaches and normative judgments. (Canguilhem, 1978. p.121)

The most useful insights that we gain from Canguilhem’s work are: (i) health and disease are concepts derived through value judgments and validated by lived in experiences of human beings and these concepts can be secondarily made objects of study of biological sciences (the discipline known as pathology), and (ii) all diseases and different health concerns, and not only mental pathology, are equally value judgments made by humans in their act of living.

We shall try to use these insights in critiquing the work of Thomas Szasz next.
Section III

Szasz and his Myth of Mental Illness

We have shown in chapter II that Szasz’s argument against the theory and practice of psychiatry is that illnesses are fundamentally phenomena of the physical body with demonstrable organic pathology, that the so called mental illnesses have no such physical correlates (and they cannot have) and thus there is nothing called mental illness. What we know as mental illness are problems of living (especially in modern age). Conditions commonly regarded as mental illness are really defined by moral evaluative criteria and not by factual and descriptive medical criteria. To term these as mental illness is in fact a metaphoric use of the concept of illness. In this section we shall briefly look at the responses made to these (Szasz’s) arguments in last few decades, discuss their merits and demerits, and formulate the arguments that can be derived from these scholars and that can be directed against Szasz’s point of view. In the next section we shall try to give further arguments against Szasz and shall then discuss some related and important issues in subsequent chapters.

R.E. Kendell’s paper ‘The Concept of Disease’ came out in 1975 and was written directly in response to Szasz’s book. Kendell took his ideas mostly from Scadding, a chest physician, to formulate the concept of disease as used in medical science and medical practice as a whole. Kendell’s main thrust was to show that mental illnesses were not fundamentally different from physical illness and thus can fit into the concept of disease. Kendell took Szasz’s primary assumption that illness is essentially a bodily concept as a given and tried to show the similarity of mental illness with physical illness (similarity argument). Thus Kendell’s argument can be stated as: disease is a concept related to body and bodily or physical diseases have some defining characteristics that allows them to be considered as disease; what psychiatry calls mental illness shares some or most of these characteristics and, therefore, they can logically be considered as diseases. Kendell’s article became popular with most psychiatrists and they adopted this similarity argument as the ultimate answer to Szasz and such other critics. Much later Pickering

32 It is not possible to do justice to all these works here and that is not our intention here. We’ll take from these authors only what is relevant to our main line of argument in the current work.
discussed this in detail and showed the logical and philosophical shortcomings of the similarity argument. We shall discuss Pickering’s work later.

Kendell, following Scadding, defined disease as something that places the organism at a ‘biological disadvantage’, meaning a disadvantage that prevents the organism from achieving the goals of optimum self preservation and biological reproduction. Species survival was the central idea behind the concept of ‘biological disadvantage’. Kendell’s definition of biological disadvantage is then simply increased mortality and reduced fertility. Referring to other and previous attempts to characterize disease through demonstrable lesions, Kendell wrote, “The concept of ‘biological disadvantage’ differs from these, however, in being more fundamental and less obviously an epiphenomenon, and in being immune to the idiosyncratic personal judgments of patients or doctors which had proved the undoing of its predecessors.” (Kendell, 1975) Despite his claims, Kendell’s theory of ‘biological disadvantage’ as a value free definition of disease does not really stand up to a thorough critical analysis. Biological disadvantage simply cannot, by itself, be sufficient as a definition of disease as there are many conditions (for example, going to war) that increase chances of mortality and reduce chances of reproduction but are not disease conditions. If one argues that such conditions are conscious decisions of risk taking it can be counter-argued that states of being poor or being involved in accident etc are not consciously taken but they definitely produce biological disadvantage and still are not disease conditions. ‘Biological disadvantage’ cannot be sufficient condition for an entity to be considered as disease. Also, human society always puts some protective boundary around its members to attenuate the natural vicissitudes. Thus a broken leg or a generally weak constitution may result in death in case of an animal living in the wild but will produce no increase in mortality or decrease in fertility in case of a human living in a protective society. On the other hand, being a ‘one eyed man in the country of blinds’ may result in the man being a king there or being murdered. Biological disadvantage simply depends on the environment the organism lives in and manmade elements enter into this environment to a large extent. As we have no means of teasing these out, biological disadvantage remains largely a matter of speculation in individual contexts. Further, there are many conditions like minor viral fever, benign skin warts etc that are considered to be diseases but that do not result in biological disadvantages.

33 Relation between accidental injuries and diseases is another problem area but for current discussion we ignore that.
disadvantage (increased mortality or reduced fertility) in any significant way. And what about homosexuality and lesbianism? They definitely reduce fertility, do not seem to be results of conscious choice ---- do we consider them to be diseases?

Christopher Boorse’s seminal and often referred article ‘On the distinction between disease and illness’ also came out in 1975 and Boorse followed it up with another journal article, ‘What a theory of mental health should be’, next year. Boorse starts with a slightly modified premise that bodily illnesses appear to be conceptually less problematic because it is easier to develop a definition of disease in case of bodily problems. “I shall assume that the idea of health ought to be analyzed by reference to physiological medicine alone. 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.” (Boorse, 1975.p.50) Boorse’s most important contribution was the distinction he made between the terms disease and illness. For him, simply put, illness is what the patient experiences and disease is what the doctor diagnoses\textsuperscript{34}. In this one stroke Boorse claims to clear away the problem of judgment-description controversy. Disease is defined as a theoretical, biological and descriptive construct that cuts across all species while illness is subjective experience arising out of disease of sufficient severity, is a normative construct, applicable only to humans and necessarily entails diminished moral accountability. Disease becomes a value-free descriptive term and thus a scientific construct. Boorse makes another claim against the normativist (Boorse’s term) view of health and ill-health. For him, health and ill-health are primarily descriptive categories and only secondarily evaluative because health happens to be a desirable thing and ill-health or illnesses are undesirable. Boorse goes on to distinguish between weak and strong normativism (Boorse’s term). “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.” (Boorse, 1975) Boorse’s argument against strong normativism is acceptable; evaluative acts cannot be the sole defining element for health and ill-health as all conditions negatively evaluated are not ill-health conditions (e.g. poverty or ugliness etc). If the claim is that

\textsuperscript{34} Notwithstanding this, in the current work, we are not maintaining the distinction between disease and illness and are using the two words interchangeably.
for a condition to be unhealthy it is necessary and sufficient that it be bad then the sufficiency claim, is demonstrably false for physiological medicine but this does not prove that the necessity claim to be false too. Boorse claims the necessity condition to be false also by citing the case of a flatfeet helping in avoidance of military drafting or the mild infection produced by inoculation. This argument is patently wrong because, first, the evaluative act of a health condition is not done by an individual in a specific context but by the accumulated wisdom of a community in judging what results in a general disadvantage (the condition should be equally disadvantageous to all, given the environmental conditions, both natural and social, are same). Use of a false medical certificate to be excused from work does not mean people usually want to fall ill in order to avoid work. Second, mild infection after inoculation is not really a wanted condition but is an unavoidable and mildly unpleasant consequence of something (inoculation) essentially good (that is, it is a necessary evil). This wisdom results from a medical knowledge, patiently gained over a long time from observation of a large number of people. People are usually willing to undergo a short term inconvenience for a long term gain. Thus acceptance of fever after inoculation is conditional and this acceptance is not an argument against the essential and negative judgment of disease in general. Despite Boorse’s claims, the weak normativist view of health and illness (that health and ill health are primarily and necessarily normative judgments) remains valid. Our understanding of Canguilhem’s works will also support this stance.

At a later date, J. C. Wakefield proposed a ‘harmful dysfunction’ model as foundation of a value free purely descriptive account of mental illness. The crucial element in this idea of a biological design is the notion of a natural function. Wakefield argues that a function in the biologist’s sense is nothing but a standard causal contribution to a goal actually pursued by the organism. 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, according to this view, its species-typical contributions to the apical goals of survival and reproduction. Biological theory is deeply committed to attributing functions to processes in plants and animals.
And the single unifying property of all recognized diseases of plants and animals, for Wakefield, appears to be that they interfere with one or more functions typically performed by all members of the species. Wakefield’s idea, applied to psychiatry and mental illness, means that mental functions are equivalent to bodily functions and serves the same purpose towards fulfillment of species-specific goals.

Wakefield’s model is very tempting in that it seems to clear the way for a value free, purely descriptive account of disease, disorder and deviation. Kendell’s biological disadvantage and Wakefield’s harmful dysfunction are closely allied concepts and are based on similar assumptions and arguments. Another similarity between them is that both the ideas derive primarily from physical or bodily conditions. The concepts advantage/disadvantage in a biological sense or the concepts useful/harmful function/dysfunction derive from our ideas of bodily functions. Both the authors explicitly or implicitly (explicit in Kendell, implicit in Wakefield) try to show the similarity between mental functions and bodily functions in order to solve the problem of mental illness. This similarity argument to prove the case of mental illness has given rise to some logical problems. Also, Wakefield’s idea, when applied to mental function, becomes basically a reductionist approach. The relation between, say, the heart and its function of pumping blood and the relation between brain and mental functions cannot be considered as same and equivalent.

At this point, having given brief accounts of the above authors’ attempts to give validity to psychiatry’s approach and produce counter-arguments against Szasz’s claims, the immediate task at our hand is twofold: (i) to see whether the arguments offered by Kendell, Boorse and Wakefield can successfully counteract Szasz’s view, and (ii) a different set of arguments can be built against Szasz’s views.

(i) We have seen that there is a common underlying assumption behind the arguments of all the above authors, Kendell, Boorse and Wakefield. They all take physical illness as the epitome of disease and assume that if we can show a large amount of similarity between physical illness and mental illness that will prove the validity of the concept of mental illness. Does this attempt have rigorous logical merit? The answer seems to be doubtful.
Pickering has shown that there are actually two forms of this similarity, or what he terms as likeness, argument. The paradigm approach is, according to Pickering, best summarized by Boorse as “a legitimate notion of mental health must be a faithful analogue of the established physical conception” (Boorse, 1977). The generic approach, on the other hand, is a concept of disease which is elicited by abstraction from the concept of bodily disease, and mental disease is then taken to be a species falling under that genus (Pickering, 2006). Both the approaches assume two basic premises: (a) that there are features of madness, or other mental phenomena, which decide what category or kind these (madness or some other mental phenomena) are member of, and (b) that, with respect to the presence or absence of these features, madness (or other mental phenomena) is describable independent of the category it is assigned to. Both the assumptions are subject to some critical analysis. Any phenomenon comprises of a large number of characteristics and when comparing between two phenomena, some of these features will be same and some will be different. Thus a simple comparison will not tell us whether they belong to the same category or not unless we have a prior agreement of significance, i.e., a prior agreement about which features are significant in the given context. And this of course entails a prior decision about the categorization itself. Thus it becomes a circular logic. The argument here is more or less same as in G. E. Moore’s ‘paradox of analysis’ which we mentioned earlier. If one takes philosophical analysis to be an attempt to say what something is then it offers an analysis of a problematic concept P by saying ‘P=Q”. But then either P and Q have the same meaning in which case the saying is trivial or they do not in which case the identity is false. Viewed thus, any attempt to validate the concept of mental illness through similarity approach will fail on logical grounds.

(ii) There can be a variation of the generic approach, mentioned above, that may circumvent the above critique. Szasz, on the one hand, and Kendell, Boorse, Wakefield etc, on the other hand, have all assumed physical illness to be the epitome of disease/illness. They all take this assumption as the starting point of their arguments but none of them anywhere has given any evidence or reason to substantiate this claim; they simply take it as granted. If we can arrive at a concept of disease without any need of specifying whether it is primarily of the physical and mental domain and can arrive at an abstract account of the features of this concept and if we can show that some features of madness to be overlapping with these disease features then there will
be no logical arguments against madness (or other mental phenomena) being categorized as illness or disease.

We believe there is no reason whatsoever to assume that disease is a concept primarily of the physical domain. Our previous discussions and the insights derived from Canguilhem clearly show that the concept of disease starts not from an objective description of a physical category but as a negative evaluation of lived experiences of humans --- both at an individual and a communal level. Our discussions on Charak show that one of the earliest known medical treatises makes no distinction between physical and mental domains when giving descriptions of disease categories. Our discussions on the etymological roots of ṛdd and ṭffa show that, at least for early Indian medical thinkers, disease was not primarily a construct of physical domain. These will show that the assumption of disease being primarily a physical concept is just an arbitrary, and not logical, one.

But, obviously, all negatively evaluated experiences are not disease or disease symptoms. Poverty is not a disease while malnutrition is, even if malnutrition is a direct result of poverty. If I am assaulted by someone and sustain a broken arm, the broken arm is a medical condition while being assaulted is not. Is it because malnutrition and broken arm are entities of the physical domain while poverty and assault are entities of the social domain? Is the binary of social—physical equivalent to the binary of mental—physical? We are thinking of such binaries here in view of determining which domain the concept of disease belongs to and which domain it does not belong to.

We think there is a confusion of thought in conceptualizing the binary domains as given above. ‘Mental – physical’ is a valid binary concept but ‘social – physical’ is not. The other valid binary is ‘social – natural’. Szasz and likeminded thinkers often make the mistake of confusing between the two different binary concepts ‘mental – physical’ and ‘social – natural’, and then collapse the two different binary concepts to produce a non-valid third binary ‘social – physical’. That way, physical becomes equivalent to natural and mental becomes equivalent to social. This is simply not true and is not logically acceptable but this confusion helps Szasz to declare anything, in the context of disease and illness, which is not physical to be a ‘social, ethical and moral’ judgment and anything physical to be beyond the ken of such judgment.
Disease is indisputably an entity of the natural domain and not of the social domain; but that does not mean it is necessarily of the physical domain. It is easy to see how the confusion arises. Objects which are knowable through human sense organs all belong to the natural world but that does not mean the natural world consists only of objects perceivable by humans but we tend to draw this erroneous conclusion often. What we really mean by distinguishing between natural and social domains is that there are entities in our universe that follow the natural laws, and thus belong to the natural world and entities in our universe that are guided by human social norms and thus belong to the social world. Whether these entities are physical or not is not the issue here all physical entities by default belong to the natural world but not all our non-physical abstract concepts belong to the social world. Marriage and climate both are equally abstract concept but marriage is member of our social domain while climate belongs to the natural world.

Next, the separation between social domain and natural domain is not a rigid water-tight one. In Hilary Putnam’s words, there is a distinction but not a dichotomy. There is a continuous interaction between the two. What we perceive as our natural world is partially man-made and our social world is partially limited by the conditions of our natural world. A chair is a natural object (being made of wood/metal/plastic – all entities of natural world) but at the same time it is an entity of our social world. The Nobel laureate biologist Sir Peter Medawar gave a beautiful example of such interaction. The ‘gold standard’ as is used in world economics and as understood in the academic discipline of economics is obviously an entity of social domain but the very existence of this social entity and its usage is possible because of certain physical and chemical properties of gold, a natural element (Medawar, 1984). Latour has also criticized modernism (or ‘modern critical stance’ in his term) for artificially purifying the division between the natural and social worlds.

Mind is not a monolithic entity; it is a conglomerate of a plethora of functions and activities occurring at multiple levels. In its totality it can span between the natural and social world. In its basic function of forming an internal representation of the world outside and producing appropriate responses to the external world mind can be construed as an entity of the natural world while in its higher level functions like abstract thinking and complex emotions and responding to other minds, it is obviously an entity of the social world. Thus, in its basic functional level, there is no logical inconsistency in the concept of mental illness.
We now come back to our original question: all diseases are first, and necessarily, negative value judgments of some lived experience but all such judged entities are not disease; how does, then, medical science decide if a particular entity is disease or not? The answer is simple – medical science judges whether the entity is subject to natural laws or not, whether the entity is a member of the natural world or not. And the criteria used for this judgment of naturalness are: (i) the condition is not unique in an individual but found in a fair number of members of a community, (ii) the condition is a cluster of component entities and the clustering cannot be accounted by chance occurrence, (iii) the condition exhibits a typical time course across all individuals harboring the condition, and (iv) the condition is beyond conscious control; it cannot be just wished away or willed in. Szasz and his followers have never taken cognizance of this simple medical approach which does not depend on whether the entity being thus considered is physical or not.

This pattern of argument and counter-argument between antipsychiatry (Szasz and others) and psychiatry (Kendell, Boorse, and Wakefield) is well summarized by Sedgwick, (often considered an antipsychiatrist): “Quite correctly, the anti-psychiatrists have pointed out that psychopathological categories refer to value judgments and that mental illness is deviancy. On the other hand, the anti-psychiatric critics themselves are wrong when they imagine physical medicine to be essentially different in its logic from psychiatry. A diagnosis of diabetes, or paresis, includes the recognition of norms and values. Anti-psychiatry can only operate by positing a mechanical and inaccurate model of physical illness and its medical diagnosis. It follows, therefore, from the above train of argument that mental illnesses can be conceptualized within the disease framework just as easily as physical maladies such as lumbago or TB.” (Sedgwick, 1982. p.56)

Having discussed Szasz’s first argument that illness is fundamentally a concept of the physical domain, we now turn to his second argument that mental illness are fundamentally social and ethical judgments and, thus, cannot properly be construed as illness.
Section IV

Madness as a Normative Concept

Szasz has famously claimed that illnesses are value-free descriptions while the alleged mental illnesses are basically value judgments and thus cannot be considered as true illnesses. According to Szasz, to call an entity a mental illness is a metaphor, a linguistic use and not a true description of reality. In Szasz’s version to term something as mental illness is a covert or overt comparison between a doctor’s belief and a patient’s belief and he considers this to be a social and ethical value judgments.

Here Szasz seems to go wrong in two counts: (i) he fails to recognize the difference between normative judgments and ethical judgments, and (ii) a normative judgment of an entity does not mean that entity cannot be an illness.

Authorities make a distinction between positive and normative statements. David Hume explained it first in 1739. A positive statement is a statement about what is and that contains no indication of approval or disapproval. A positive statement can be wrong. Famously, "The moon is made of green cheese" is incorrect, but it is a positive statement because it is a statement about what exists or not. A normative statement expresses a judgment about whether a situation is desirable or undesirable. "The world would be a better place if the moon were made of green cheese" is a normative statement because it expresses a desire and a judgment about what ought to be. Notice that there is no way of disproving this statement. If one disagrees with it, one has no sure way of convincing another who believes the statement that she is wrong.

Norms are sets of rules or standards that determine the desirability of human behavior, the ‘ought’-ness in human world. At the minimal they express a desire what a particular entity should be. By definition they operate in human world and can have no role in natural world. Natural world is governed by what we recognize as natural laws. As such norms and laws are distinct but comparable as governing entities in these two worlds. Thus, norms and laws are similar categories operating in two different worlds but ethical judgments express a different
kind of ‘ought’-ness or wish in the human world. To make life and living possible, it is necessary to conform to certain sets of behavior and, in human social world, these sets of behavior constitute the norms. A normative judgment basically means that a failure to comply with these norms will render life and living difficult in a fundamental sense whereas an ethical judgment basically differentiates between good and bad and these are purely human constructs. Canguilhem quotes Bergson to make the normative nature of living clear: “Whether human or animal, a society is an organization; it implies a coordination and generally also a subordination of elements; it therefore exhibits, whether merely embodied in life or, in addition, specifically formulated, a collection of rules and laws.” (Canguilhem, 1978. p.296) Canguilhem goes on to claim that life itself is a normative activity and, in this sense, all diseases are basically normative judgments as deviations from a norm. OTPP explains: “The terms normative and evaluative are used sometimes as synonymous and sometimes with different meanings. In one fairly widespread use in philosophy, evaluating is a subclass of normative. Normative implies rule following where the rules in question are human in origin (e.g. the rules of a game) as distinct from natural laws. Evaluative, according to this way of marking the distinction, is used only where the rules in question are about judgments of good and bad (aesthetic, moral, prudential, epistemic, etc.).” (OTPP, 2006. p.217) Thus, mental illness, as all illnesses are, is surely a normative judgment but equally surely is not an ethical judgment and this is where Szasz’s argument fails to convince.

The phenomenon of madness is also equally a normative judgment and not an ethical judgment. But saying that illness and/or madness are normative judgments does not exhaust their analysis; they also represent a problem in the natural realm. Diseases represent an ‘error’ in dealing with natural (here biological) laws. We have seen that the judgment of madness involves the level of basic cognitive functioning; in perceiving and interpreting the world in an appropriate way, in forming the correct mental representation of the outside world. Is this basic level of mental functioning part of the realm of human norms or a part of the realm of natural laws? This question proposes a possible continuity between the natural world and the mental sphere. For someone maintaining a sharp boundary between the two, the above doubt will be meaningless but current understanding of cognitive neurosciences denies this sharp boundary. Our above discussion of faulty appraisal of one’s environment as the core of the experience of madness will
indicate that at this basic and fundamental level, psychological functions are actually entities
governed by natural laws and not by man-made norms. Thus, the judgment of madness cannot be
only a normative judgment in the sense of indicating a deviation from a man-made norm but an
indicator of deviation from natural laws also.

But deviation from natural laws is a meaningless statement. Natural laws are universal and in the
natural world, there can be no instance of bending of a natural law, no instance of a phenomenon
flouting a natural law. How do we then conceptualize this ‘deviation of natural law’? There is
one model that can accommodate this seeming contradiction ---- that of the machine. A machine
is an entity, man-made or not, that functions in a predetermined way, employing different natural
laws in a harmonious way to achieve a predetermined goal. A failure or malfunction of the
internal structure of the machine will basically disrupt this harmony resulting in failure to
achieve this goal. Take, for example, the case of an automobile car. It is a machine designed to
utilize energy derived from burning of fuel, from an internal combustion chamber, to drive a
crank-shaft that intern rotates the wheels resulting in propagation of the whole of the machine.
But a malfunctioning spark plug or a flat tyre will impede this functioning. In case of a faulty
spark plug the fuel will not ignite and in case of a flat tyre the friction between ground and wheel
will make progress difficult. Or take the case of a tree sapling. It has a predetermined potential to
grow into a tree of certain shape and size but environmental conditions like availability of water
and sunlight will determine how far the potential will be actualized. In none of these cases was
any natural law broken but the smooth harmony between different natural laws was broken and
the clash between different natural laws made carrying out of the potentialities of the car or the
tree impaired. This machine model, if applied to ‘mind’ in its basic functions can explain the
occurrence of madness. ‘Mind’ in its basic functions is like a machine, geared to perform some
specific functions and a malfunction of this machinery prevents carrying out of the usual smooth
functioning of mind and gives rise to different and/or odd behaviors that we call madness. We
shall discuss in more details the case of the tree sapling and its potentialities later when we
discuss the concepts of telos and dysfunctions.
Section V
Other Problems with Szasz’s Argument

In context of the description/evaluation controversy, Szasz’s arguments lead to other problems. Szasz suggests that normative judgments define mental illness and this undermines its status as a scientific concept. These judgments involve ‘a covert comparison between the patient’s ideas and those of the observer and the society in which they live’ (Szasz, 1973. p.14). Tim Thornton notes that, “[the argument] blurs the distinction between how we might know that a subject is deluded ---- perhaps by comparison with what we think ---- and what it is to be deluded. That is, he blurs epistemology and ontology here” (Thornton, 2007. p.15). Our understanding of Karl Jaspers’ work will indicate that it is not simply a question of comparing between two beliefs but a complicated attempt to understand what it means to be deluded, how a person comes to hold the false belief. Jaspers’ work shows that a decision of someone being mentally ill is not taken simply by the presence of a false belief but through the analysis of primary and secondary delusions, delusional moods, and secondary elaborations of a delusional belief. Apparently, Szasz was unaware of Jaspers’ contribution.

According to Szasz, to understand the metaphorical nature of the term "disease" in psychiatry, one must first understand its literal meaning in the rest of medicine. To be a true disease, the entity must first, somehow be capable of being approached, measured, or tested in scientific fashion. Second, to be confirmed as a disease, a condition must demonstrate pathology at the cellular or molecular level. “The concept of illness, whether bodily or mental, implies deviation from some clearly defined norm. In the case of physical illness, the norm is the structural and functional integrity of the human body.” (Szasz, 1960. p.114). We have already discussed Szasz’s notion that disease is fundamentally a physical entity. Here, it is not clear from Szasz’s writing whether he considers these demonstrable pathologies as necessary correlates of disease or causative explanations of disease. In either case the argument is patently wrong because many physical diseases were identified and even treated with at least some success decades, centuries or millennia before their etiology was accurately identified. A disease does not become a disease when, and only when, a demonstrable pathology or a causative etiology is identified; it has
already been considered a disease long before these were identified. Epilepsy, diabetes mellitus, malaria etc are common examples. In fact, for most diseases, identification has been historically done through identification of symptom clusters and physical correlates and etiological knowledge comes much later. For many conditions, like migraine, we have neither etiological knowledge nor physical correlates but that does not take away their disease status. Knowledge about physical correlates or etiology is time dependant, dependant on state of investigative technology available and available scientific information. Hundred years back we did not know of any correlate or cause of diabetes, now we know some of these: does that mean diabetes was not a disease and a myth hundred years back but has become a disease now? The argument here is: it is not necessary to have physical correlates to identify an entity as disease. That does not mean every entity that we don’t know the physical correlate of can be considered a disease. It should now be obvious that definition of disease cannot depend on available information about cause or physical correlates. The view that disease is primarily a physical entity is itself a product of developments in medical science of last two- to three- hundred years but disease is not purely a concept of medical science. Irrespective of how medical science defines disease, disease is an important conceptual construct developed within society, with widespread use within society and with a rich history that far antedates modern medical notions.

To demonstrate another problem with Szasz’s thought we need to quote him again: “Correctly speaking, however, these are diseases of the brain, not of the mind. According to one school of thought, all so-called mental illness is of this type. The assumption is made that some neurological defect, perhaps a very subtle one, will ultimately be found for all the disorders of thinking and behavior. Many contemporary psychiatrists, physicians, and other scientists hold this view. This position implies that people cannot have troubles -- expressed in what are now called "mental illnesses" -- because of differences in personal needs, opinions, social aspirations, values, and so on. All problems in living are attributed to physicochemical processes which in due time will be discovered by medical research.” (Szasz, 1960. p.113, italics in the original) And also, “[the] word "psychiatry" here refer[s] to that contemporary discipline which is concerned with problems in living (and not with diseases of the brain, which are problems for neurology)”. (Szasz, 1960. p. 14) This is indeed a very strange view to take. On the one hand, if what Szasz claims is true, ‘problems of living’ become by nature unexplainable through
‘physiochemical process’ ----- a stance basically of Cartesian mind-body substance dualism ----- philosophically a problematic stance in today’s understanding. On the other hand, Szasz seems to imply that if an experiential phenomenon can be understood through physiochemical mechanism or is reduced to a physiochemical mechanism it automatically becomes an object of medical study, becomes a medical pathology. What Szasz fails to recognize is that all human experiences, physical or mental, all our daily activities like eating, sleeping etc, must necessarily have physiochemical correlates and these correlates are potentially knowable. This does not mean that experiences get reduced to physiochemical process or that physiochemical processes can provide sufficient causative explanations of experiences. Even then, having ‘unbiased’ descriptions of these physiochemical (or anatomical, or physiological) will not tell us which of these experiences are good to have or not, or in other words, which are healthy and which are not.

Szasz’s critique of identification of psychopathology as covert comparison between the ideas of the patient and the diagnostician is based on the single example of the case of delusion. Michelle Foucault also makes the same use of delusions. While Foucault’s book title is *Histoire de la folie* where folie can be translated into English as madness, in the book he often uses the word *delire* which is equivalent to delirium in English but French usage means a delusion rather than a confusional state as it means in today’s psychiatric English use. Szasz’s implied mind-body dualism largely derives from the same example as delusion can be viewed as a purely mental phenomenon. But delusion is only one of all the possible psychopathologies. Can ‘covert comparison’ explain all other psychopathology like morbid anxiety, obsession, thought diffusion, altered perception etc? Besides, is anxiety a purely mental phenomenon? Our subjective awareness of our bodily functions and our subjective awareness of our mental functions are intricately mixed up in our experience of anxiety and this poses serious challenge to the mind-body dualism theory.

We have, this far, tried to show the logical inconsistencies of Szasz’s views. In order to do so we have followed the already available arguments against Szasz. We have taken a critical look at these already available counter-arguments and judged their success/failure in countermanding Szasz’s views. We have noted the pitfalls of the similarity/likeness arguments and have tried to
show how these pitfalls can be avoided. Now we have to discuss another aspect of these available arguments. Kendell, Boorse, Wakefield all talk about biological disadvantage, dysfunction and similar concepts. We need to have a closer look at these concepts and try to judge their validity and related issues.

Section VI

Disadvantage, Dysfunction and Telos

Advantage and disadvantage are words that can be understood only in a specific context. Advantage or disadvantage towards what? Something being advantageous or disadvantageous in general does not really convey any meaning to us. Having a pencil is advantageous only when one plans to write something; otherwise a pencil is a neutral object. Not having a pencil is again disadvantageous only when one plans to write something; otherwise the absence does not matter. This presupposes a planned activity towards a specific goal. When we talk about biological function, we tend to assume (as Kendell does) self-preservation and reproduction as such goals in biological world.

Function and dysfunction are again words that can be understood only in a specific context. Function presupposes a process that has a predetermined goal. An entity (machine, organ etc) can have a function only if it is in a process of change and the change is towards a prefixed goal. When we talk about a biological function, the concept becomes parallel to the concept of biological advantage/disadvantage and has to assume the same set of phenomena (self-preservation and reproduction) as goals.

If we are to decide whether a particular phenomenon (disease/illness/distress) in an organism is biologically disadvantageous or a harmful dysfunction or not, there has to be a particular goal for
the organism and we must have prior knowledge of that goal. This brings us to the question of biological teleology. Telos (from the Greek τέλος) is an end or purpose or goal. Teleology is a branch of philosophy that is roughly the study of purposiveness or the study of objects with a view to their aims, purposes, or intentions. In other words, teleology is an attempt to provide causal explanation of a phenomenon through its telos; telos explains why a certain entity exists or is what it is. Thus, a teleological attempt at explanation presupposes two things: first, the entity to be explained has a purpose of existence and second, the purpose is known (or knowable) to us. Teleology as a branch of philosophy started from Plato and Aristotle and from the beginning it has faced criticisms for the above two assumptions. Lucretius declared, “Nothing in the body is made in order that we may use it. What happens to exist is the cause of its use.” We are still struggling between the two views, especially in the field of biology.

Let us look at the three statements below:

(i) Purpose of the knife is to cut.
(ii) Purpose of the tree is to bear fruit.
(iii) Purpose of the earth is to revolve around the sun.

Each of these statements derives from similar observations and the reasoning that leads to the statements from these observations is similar. The first statement is non-controversial; the second most will take as true. The third appears inane and meaningless to us but to Plato and Aristotle they probably would have been acceptable. As Zeller puts it: “Still more important for him [Aristotle] is the principle that the process of nature is not to be regarded as a physical activity, but as tending rather towards a definite end. The end and aim of all becoming is the development of potentiality to actuality, the incorporation of the form in matter. Thus in the Aristotelian doctrine of form and matter, just as in the platonic theory of ideas, the teleological explanation of nature predominates over the physical” (Zeller, 1933. p.179). We cannot, today, take this view not only because we can no more use Plato’s concept of demiurge or Aristotle’s concept of ‘nature’ but because our ideas of causal explanation has changed. Teleological statements are occasionally met with in natural sciences (physics and chemistry) like in the concept of entropy
or the behavior of gases or of any process tending towards an equilibrium but in these cases the teleological view is only apparent because purely causal explanations can fully account for the phenomena and the telos itself gets explained by the causal processes. In case of manmade world, in case of machines, teleology is a valid explanation of things; machines are made with a particular functional outcome in mind or, in other words they are designed. In case of biological world, the situation is complicated. Evolutionary biology often employs teleological terms but this is only apparent as a strictly Darwinian explanation through the process of natural selection can give adequate causal explanation of biological evolution. Evolution, strictly speaking, is rather an unfortunate term to use in context of Darwinian theory. Evolution inherently implies something changing towards a better state. What Darwin talks about is whether a particular species is fit to its immediate environment or not and if the environment changes, how the species changes to a new one to fit the new environment. The fitness is only contextual to a particular environment and no species is better than another in any absolute sense. Thus *Homo sapiens* (humans) are no better a species than *Periplaneta americana* (cockroach) in any Darwinian sense. The other idea of evolution as a gradual process towards betterment at each successive stage is an idea developed by Herbert Spencer. The idea that human beings are the (as yet) culmination of biological evolution and the continuation of that evolution into human social systems (social Darwinism) results from purely human values and not from any unbiased observation of animate and inanimate nature.

In the biological world, we observe a process of birth → growth → reproduction → decay → death and repetition of the same cycle in the next generation. We also observe different biological organs do something that is useful to maintain the above cycle for the organism. These observations lead us to perceive an overall purposiveness in the biological world in general and in individual organisms in particular. What is to be remembered is that all these phenomena can be explained in terms of purely causal laws. We being part of the living world and having a sense of purposiveness within our subjective awareness tend to generalize the purposiveness to the entire living world. There is inherently nothing wrong in a teleological view of biology if it has good explanatory purpose but we must remember that this view is inextricably linked with a purely human value. Of the two statements ‘purpose of life is to live and reproduce’ and ‘purpose of life is to die’ obviously the first one appeals and appears true to us while the second
one appears absurd but an unbiased observation of biological world would be equivocal in lending support to either of the two statements. In Zettel, Wittgenstein writes: “I am inclined to think of a lifeless thing as lacking something. I see life definitely as a plus, as something added to a lifeless thing” (Wittgenstein, 1967. 128. p.24e). Obviously, whether life is seen as a plus or a minus or a neutral entity is a value judgment and not given in the definition or description of life.

Philosopher R. M. Hare wrote, “It is only if we extend the notion of wanting …. that we can reveal the origins of expressions like ‘good roots’ from which naturalists have drawn such sustenance; the apple tree’s good roots, if they are not good for helping it produce the sort and the quantity of apples that I want, must be good for helping it to grow into the kind of apple tree that it wants to be—i.e. to achieve the telos or end of apple trees by putting on as perfectly as possible their eidos or form. If we had not inherited a great deal of this teleological language, we should not speak of good roots in the case of trees not serving a human purpose (Hare, 1972. p.99). The rich heritage of teleological language may serve as an explanatory tool to understand the living world and its disorders but that does not mean they are value free descriptions of the biological world. The concepts of Kendell or Wakefield cannot really be value free descriptions. Disease, illness, disorder are biological concepts and these concepts are products of a teleological view of the living world and this view is imbued in human values. “Biological pathology exists but there is no physical or chemical or mechanical pathology.” (Canguilhem, 1978. p.127) Thus, using concepts like biological disadvantage or dysfunction does not really give us a value-free purely descriptive account of disease

So we are left with the position that diseases in general and madness and mental illness in particular are inexorably value judgments but that can only be half of the story. Unless we also have a valid description of the conditions, we cannot proceed further. Being valued negatively cannot automatically categorize a condition as illness. Can value and description be somehow reconciled? Hilary Putnam has pointed out that fact and value have a distinction between them but are not dichotomous or dualistic ideas (Putnam, 2002). A distinction can be drawn at certain occasions but a dichotomy holds true for all occasions; a dichotomy is a non-collapsible difference while distinction is not. R. M. Hare showed that value judgments are made on the basis of criteria that are themselves descriptive. To use Hare’s own example, a good strawberry
is one that is ‘sweet and grub-free’. This is actually a two way process: judgment depends on available (may be implicitly known) description and what is being judged can be objectively studied to arrive at a description. That a strawberry is good (to taste) can be judged by visual description because accumulated experience has taught us to associate a particular visual description with a particular taste. On the other hand, when a strawberry is judged as good to taste, it can be studied objectively to understand what (sweetness etc) makes it good to taste. Where values are widely agreed and settled upon, descriptions and value terms may replace each other or get mixed. “Value terms by which shared values are expressed may come, by a process of simple association, to look like descriptive (or factual) terms, whereas value terms expressing values over which there is disagreement, remain overtly value laden in use”. (Thornton, 2007, p.25, writing on R. M. Hare, italics in original). We get two advantageous notions here: first that there is no inherent contradiction in accepting that identification of madness and mental illness are normative judgments but they can also have unbiased descriptions, and second, judgments about madness and mental illness are not individual idiosyncratic judgments but are result of widely shared values of the community.
Reference:


