

MENTAL HEALTH AS RATIONAL AUTONOMY*

ABSTRACT. Rather than eliminate the terms "mental health and illness" because of the grave moral consequences of psychiatric labeling, conservative definitions are proposed and defended. Mental health is rational autonomy, and mental illness is the sustained loss of such. Key terms are explained, advantages are explored, and alternative concepts are criticized. The value and descriptive components of all such definitions are consciously acknowledged. Where rational autonomy is intact, mental hospitals and psychotherapists should not think of themselves as treating an illness. Instead, they are functioning as applied axiologists, moral educators, spiritual mentors, etc. They deal with what Szasz has called "personal, social, and ethical problems in living." But mental illness is real.

It has often been noted that psychiatric labeling has grave moral consequences, i.e. consequences which seriously affect the moral standing, rights, and quality of life of other people. In the name of supposedly scientific and objective medicine, it legitimatizes the enormous power which psychiatrists and mental institutions have over other people, especially the weaker and more vulnerable members of society. Psychiatric labeling is a form of moral as well as medical behavior which has clear disadvantages as well as clear advantages. On the debit side, it serves to isolate socially those persons to whom labels of lunacy are applied; and it often generates enormous mistrust and alienation between them and their family and friends. It permanently stigmatizes those so characterized and negatively affects for years to come their opportunities for such basic amenities as self respect, employment, promotion, housing, education, marriage and general social trust and acceptance. It dehumanizes and degrades those to whom it is applied, allowing us to regard and treat the mentally ill as slightly less than human. Nevertheless, it may still

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be a rationally acceptable and justifiable mode of inter-personal interaction, despite its obvious moral liabilities. Recognizing that psychiatric labeling of individual persons may have grave consequences, we should also acknowledge that the very act of defining and providing a range of application for such concepts as 'mental health' and 'mental illness' is itself a moral act which greatly affects the lives of others.

There is both an evaluative and a descriptive dimension to our concepts of 'mental health' and 'mental illness.' The latter term applies to describable mental and/or behavioral deviations of which we strongly disapprove. In addition to statistical abnormality, the disapproval element is a necessary condition for applying the term; for there are many 'healthy' minority deviations of which we strongly approve, such as the rare but precious intellectual genius, creativity and sensitivity of our most outstanding artists, writers, scientists, philosophers, and moral and religious leaders. It is a great but often made mistake, however, to allow statistical deviation and the disapproval element to be sufficient conditions for applying the notion of 'mental illness,' for then we must allow every peculiar mental/behavioral process of which we disapprove to count as a mental illness. To avoid the excesses into which so much of psychiatry has lapsed in recent years, we must allow the notion to be applied only to a small sub-class of disapproved psychic processes, distresses and behaviors. The issue is: do we wish to medicalize the whole of life, or do we wish instead to recognize and preserve other evaluative realms of discourse such as that of intrinsic value and disvalue, as well as distinctive moral, political, and religious norms?

Our present problem is not merely of academic interest, for there is a powerful tendency at work in modern secular, scientific society to allow older religious and moral values simply to fade away and to medicalize the whole sphere of moral, political, and religious deviation. When confronted by conditions and behaviors of which we disapprove, so many of us no longer use such ethico-religious terms as 'ungodly,' 'sinful,' and 'immoral,' or even such political terms as 'unjust' or 'undemocratic.' Instead we apply such highly evaluative pseudo-scientific terms as 'sick,' 'unhealthy,' 'immature,' 'a sad case,' etc. We often do not realize that this whole way of talking tends to put ministers, political activists, and even serious minded moralists as such out of business. Physicians and psychiatrists become the secular priests and final arbiters of what we should value and disvalue — in the name of 'empirical' medicine. Many recent

authors such as René Dubos, Ivan Illich, Nicholas Kittrie and Thomas Szasz have condemned such creeping medical imperialism and totalitarianism for a variety of reasons. Some protestors do so simply because they wish to make a place for moral, political and religious norms and deviations which should not be confused with or collapsed into an all embracing domain of 'mental health' and 'mental illness.' This may involve recognizing and respecting other intrinsic, moral, social, political and religious values and disvalues in their own right. E. Fuller Torrey was doing this when he criticized as follows the 1977 report of President Carter's Commission on Mental Health, which equated mental illness with the unhappiness which results from social injustice, discrimination and poverty:

Certainly poverty and discrimination are terrible injustices that cause widespread anguish and unhappiness. But anguish and unhappiness are not mental illness, and herein lies the confusion. Poverty and discrimination are no more 'mental health' problems than famine and war. They are human problems and should be attacked as such, with all the governmental and private resources at our disposal: jobs must be created; opportunities equalized; housing built; food supplies fairly distributed. Labeling them mental-health problems not only obscures their true importance but also creates the illusion that they can be 'cured' if we will only put enough mental-health professionals into positions of power (Torrey, 1977, p. 10).

Resisting medical imperialism in psychiatric labeling may also involve an awareness of the grave moral consequences of psychiatric name calling, or an appreciation of the horrendous physical and psychic consequences of much that passes for 'therapy,' or a sense of the desirability of protecting the integrity of language itself. Economic considerations also are very much involved in any decision to expand or restrict our notion of 'illness,' even of 'mental illness.' If a condition gets classified as an illness, insurance companies and government agencies such as Medicare and Medicaid will be expected to pay the bills in many cases; and if the condition is not so classified, these agencies will not pay. There are many good reasons for wanting to limit the scope of application for the notion of 'mental illness,' rather than allow it to swallow up *all* those states of mind, distresses and deviant behaviors of which we disapprove. Surely things have gotten way out of hand when a psychoanalyst such as Fine (1967, p. 95) tells us, "neurosis is defined in the analytic sense as distance from the ideal; then it can be said to affect 99 percent of the population. Thus, the essential thesis of this paper emerges: The ultimate goal of psychoanalysis is the reform of society."

I shall now make a conservative proposal for the proper limitation of the very notion of 'mental illness' which until recently has been a presupposition of our entire legal system, which is very close to what I have found many mental health professionals actually using in their work in mental hospitals, and which is also very close to what the term traditionally meant before the advent of the sort of medical imperialism which Kittrie (1971, pp. 340–410) has called "the therapeutic state," or which Illich (1976, pp. 31–60) has called "the medicalization of life." There is nothing final about this proposal. It is merely an attempt to generate a discussion of the proper limits of 'mental illness,' *recognizing that the lives of many people will be greatly affected by where we draw the line.*

Definition: 'Mental illness' means only those undesirable mental/behavioral deviations which involve primarily an extreme and prolonged inability to know and deal in a rational and autonomous way with oneself and one's social and physical environment. In other words, madness is extreme and prolonged practical irrationality and irresponsibility. Correspondingly, 'mental health' includes only those desirable mental/behavioral normalities and occasional abnormalities which enable us to know and deal in a rational and autonomous way with ourselves and our social and physical environment. In other words, mental health is practical rationality and responsibility. A number of other theorists such as Breggin (1974, 1975), Englehardt, Jr. (1973), Fingarette (1972) and Moore (1975), have arrived at similar views.

There is much here that needs explaining. By 'mental/behavioral' I mean thinking, willing and feeling which may manifest itself in publicly observable bodily alterations and activities. By 'autonomy' I mean having and freely actualizing a capacity for making one's own choices, managing one's own practical affairs and assuming responsibility for one's own life, its station and its duties. Before defining 'rationality,' and specifying its relevant realm of application, let us first recognize that there is a large domain of human belief which falls quite legitimately into the category of contested beliefs and unanswered questions, and which should be regarded as only peripherally relevant to the identification of madness. Most of our political, philosophical and religious beliefs, many scientific and factual beliefs, and many questions of value and practice belong to the class of contested beliefs and unanswered questions. There is no clear answer to what it is and what it is not rational to believe in these areas. I keep telling my colleagues in philosophy that in such

matters, there is very little difference between being around a mental hospital and being around a department of philosophy! Political, philosophical and religious beliefs especially should never provide us with *primary* grounds for diagnosing mental illness. If that restriction had been observed, attempts would not have been made to have Mary Baker Eddy declared insane and institutionalized involuntarily for being a Christian Scientist. Nor would Ezra Pound have been institutionalized for political dissent. Irrationality and irresponsibility with respect to knowing and dealing with oneself and one's social and physical environment should be the primary focus for defining and diagnosing mental illness. We cannot declare a Christian Scientist mentally ill for believing that a broken bone has been miraculously healed if indeed no fractures show up any longer on X-rays. However, if anyone for any reason insists that healing has occurred when the fractures are still showing up, or if a woman insists that she has a million children and spends all her time looking for them, or if someone insists that they no longer need to eat since they died yesterday and are now in Heaven, then questions of sanity may be very legitimately raised and would be so raised even by Christian Scientists. True, there will be some tough marginal cases such as that of the sociopath; but some cases will be clear enough. Situations will also arise in which philosophical and religious beliefs impinge upon personal, empirical and social realities, but mental illness should not be diagnosed unless it manifests itself in these practical areas.

Are we all just a little bit crazy, as some psychotherapists and much of our popular wisdom and humor insinuate? This depends in part on whether we are willing to call *any* momentary lapse into irrationality and irresponsibility a form of 'mental illness,' or whether we wish to reserve the term only for extreme and persistent forms of such. Because of the grave consequences of psychiatric labeling, it seems morally desirable to limit it to the latter, and I am offering a moral argument for a very limited and conservative conception of 'mental illness.' As for the factors of duration and degree, there is no *precise* answer to the question of 'how long?' or 'how extreme?'. But it seems both socially undesirable and linguistically unconventional (at least prior to our recent medicalization of the whole of life) to count momentary and relatively superficial confusions, lapses of memory, emotional traumas and perceptual errors, etc. as indications of mental illness. A moment of confusion does not count as a mental illness any more than a single sneeze counts as a respiratory

disease. The concept of duration belongs in our definitions of all diseases. On my analysis, mental illness will be a matter of degree of both time and severity of impairment and as such will be on a continuum with the whole of life; and there will be a grey area of controversial borderline cases. But some instances of it will be unmistakable in their duration and degree. If we take the duration factor seriously, there will be no such thing as temporary insanity, but this has never been anything more than a legal fiction invented for excusing certain persons when no other legal rationale for doing so could be found. It is important that we understand that only relatively extreme forms of such mental/behavioral malfunctions count as mental disorders. Though the question is worth exploring, we should be wary of altering this to mean that any such malfunction which is *capable* of taking an extreme form is a mental illness, for then we would be right back to the medicalization of the whole of life. It should also be noted that the factual claim that extreme mental/behavioral malfunctions are grounded in some 'underlying pathology,' located in the brain, the unconscious, the enduring structure of the mind itself, or what have you, has not been built into our definition of mental illness. This is a hotly contested issue, especially between behaviorally oriented psychologists and their adversaries; and such a consideration can be introduced only when it has been confronted head-on and found to be justified. All the data are not in on this one yet.

Now, what is meant by 'rational?' Whatever it is, mental disorders are shortcomings or departures from it, and only those disorders which involve the absence of it are to count as mental disorders. Other undesirable mental/behavioral deviations should be classified in other ways, such as intrinsically bad, immoral, criminal, irreligious, etc. There are a number of defining elements in our common notion of 'rationality.' This is an important word in our living languages, not a technical word invented by philosophers. But philosophers may contribute to its clarification, and there is widespread agreement among both philosophers and non-philosophers that rationality involves (1) being able to distinguish means from ends and being able to identify processes and manifest behaviors which likely will result in the realization of consciously envisioned goals; (2) thinking logically and avoiding logically contradictory beliefs; (3) having factual beliefs which are adequately supported by empirical evidence, or at least avoiding factual beliefs which are plainly falsified by experience; (4) having and being able to give reasons for one's behavior

and beliefs; (5) thinking clearly and intelligibly, and avoiding confusion and nonsense; (6) having and exhibiting a capacity for impartiality or fair mindedness in judging and adopting beliefs; (7) having values which have been (or would be) adopted under conditions of freedom, enlightenment, and impartiality. Rationality is a function of how we know, not of what we know. Ignorance is not insanity, but irrationality is. Stupidity, the deliberate choice of self-defeating ends, is also not insanity.

I am fully aware that many books could be and have in fact been written explicating all the complications of and full conceptual significance of these seven defining features of 'rationality,' but I do not have space here to rewrite such books. I do think that the last element is so difficult to apply that it should never be used in diagnosing insanity, though it has very legitimate philosophical uses. For purposes of defining 'mental illness,' I hope that enough has been said to indicate the sort of direction in which the notions of 'rationality' and 'irrationality' as deviations from such, have been traditionally understood. Of course, there are all sorts of degrees in the development of our human capacity for rationality, and it is only fairly extreme and persistent departures from some of our seven defining features of rationality which count as mental illness. Only a few of these factors need be involved in any particular case. Most people are not *very* rational, but most people are nevertheless sane. *Extreme* departures from sanity are not as difficult to identify in practice as some skeptical critics, especially lawyers and philosophers who have never spent any time around mentally disturbed persons, would have us to believe. Cases on the borderline of such extremities are the ones which understandably give headaches to mental health professionals, but such professionals can also cite many clear cut cases involving extreme and prolonged incompetence and self-defeating performances in selecting effective means to avowed ends, of radically inconsistent practical belief systems, items of which are plainly controverted by empirical facts, of inability to cite reasons for belief and behavior, of persisting and pervasive conceptual confusions, and of entrenched inabilities to adopt fair minded perspectives on either factual or valuational beliefs.

Since being rational involves having and acting upon factual beliefs supported by common experience and avoiding beliefs clearly at odds with common experience, it is easy to understand how persisting hallucinations and perceptual distortions contribute to irrationality. They involve loss of contact with our common world and generate

beliefs about and behaviors directed toward things that are just not there. To the extent that unconscious conflicts, powers and processes interfere with the functioning of conscious rational autonomy, they too are relevant for diagnosing mental illness.

No account of underlying pathology in the brain or in a Freudian psyche has been built into the definition here proposed of mental illness as loss of practical rational autonomy. Neither has the attempt to correlate mental illness with such pathology been excluded by such an analysis. Indeed, I wish to encourage an exploration of possible connections between mental illness so conceived and current concepts of and research on organic brain pathology, the standard functional psychoses and neuroses, and mental retardation. My suspicion is that standard (and desirable) brain structure, function and chemistry can be correlated with all manifestations of rational autonomy, even if the precise relation between them always remains shrouded in metaphysical mystery. Though we do not know precisely how conscious thought and decision processes are related to brain function, we might still find that predictable correlations can be made between consciousness and brain. We might discover, and to some extent have actually found, that physical therapies such as psychotropic drugs, electroshock and even carefully controlled psychosurgery have predictable connections with restoration to rational autonomy and mental health. True, drugs *may* be used as 'chemical straight jackets.' They may also be used to correct an imbalance in the dopamine circuit of the brain of the schizophrenic. A renewal of rational autonomy may thus be correlated experimentally with a return to more normal brain chemistry. The medical model is not included in our concept of mental illness/health, but its relevance is not excluded either. In this area much work remains to be done.

The problem of placing proper limits on the notion of mental disorder becomes especially acute when it is allowed to range over the whole spectrum of disapproved mental/behavioral phenomena, including those which have little or nothing to do with breakdowns of rational autonomy, but which still might be disapproved on moral, legal, or religious grounds. It is not very difficult to see that schizophrenics, paranoids, and manic depressives, etc. are irrational and have lost control; but many people certainly have great difficulty seeing that irrationality has much to do with many other conditions which are often classified as mental disturbances. An example of such a highly controversial classification would be homosexuality uncomplicated by distress, which was listed in 1968

as a mental disorder in the A.P.A.'s *Diagnostic and Statistical Manual of Mental Disorders, II*, but which is not listed in the new *DSM-III* in 1980. Has Anita Bryant persuaded us that this is really an ethico-religious problem after all, or have we been convinced that it is really no problem at all? In the 19th century, masturbation was regarded as a manifestation of madness and treated with the harshest of imaginable 'therapies,' but few persons even disapprove of it these days, much less classify it as madness. *DSM-III* includes caffeinism and excessive smoking as mental disorders. Will these have the same ultimate fate as masturbation? Anyone who has read Szasz (1972) knows that alcoholism and drug addictions are very debatable categories of mental illness. As he puts it, "Bad habits are not disease: a refutation of the claim that alcoholism is a disease." Is alcoholism a mental or a moral problem? My own view is that alcohol abuse begins as a moral problem and ends as a mental disease as it gradually becomes physically addictive, deprives the individual of much rational autonomy, and in some cases (Korsakov's psychosis) turns the brain to mush. I shall not attempt to work through *DSM-II* or *DSM-III* in detail to see which diagnostic categories might involve a confusion of irrationality with immorality or irreligion. Let the A.P.A. do that! I wish only to assert that not every disapproved mental/behavioral phenomenon should count as mental illness, that we should make a concerted effort to disentangle legitimate psychiatric valuations from moral and religious ones, and that we should attempt to put a screeching halt to the rampant proliferation of psychiatric diagnostic categories because of the grossly detrimental effects of the very act of psychiatric labeling if for no other reason. I am convinced that psychiatric labeling does have legitimate uses, but it also has illegitimate ones, and it will be the mark of the wise psychiatrist, psychologist and philosopher to be able to distinguish the two.

No doubt, many psychologists and psychiatrists will want to reject the definitions of 'mental illness' and 'mental health' here proposed. This is not a great embarrassment, however, for there is *no* definition of these terms anywhere in the literature that many psychologists and psychiatrists would not want to reject. One of the truly embarrassing aspects of this field of medicine is that there is so little agreement on theoretical fundamentals. This always adds fuel to the fire of those who insist that the 'medical model' has no legitimate application to mental/behavioral disorders. Why should anyone want to reject the conservative definition of 'mental illness' in terms of

impairment of rational autonomy here being proposed? I am confident that most objections will be based upon the tendency inherent in all medical imperialism to engulf all disapproved mental/behavioral conditions and processes under the label of 'sick,' and to recognize no separate domains of intrinsic, social, moral, political, legal and religious values and disvalues.

The same imperialistic tendency is at work when we come to positive conceptions of 'mental health.' The tendency in so many cases is to equate this with *everything* desirable, not simply with the desirability of rational autonomy. *Every* desirable mode of experience, activity, self-realization, happiness and social organization are packed into imperialistic conceptions of 'mental health.' Consider and analyze for yourself the intrinsic, social, moral, religious, legal, etc. values which are packed into the following definitions.

1. "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (The World Health Organization, 1978, p. 89).

2. "The crucial consideration in determining human normality is whether the individual is an asset or a burden to society and whether he is or is not contributing to the progressive development of man" (Alfred Adler as summarized by O. H. Mower in Boorse, 1976, p. 69).

3. "Let us define mental health as the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness. Not just efficiency, or just contentment — or the grace of obeying the rules of the game cheerfully. It is all of these together. It is the ability to maintain an even temper, an alert intelligence, socially considerate behavior, and a happy disposition. This, I think, is a healthy mind" (Karl Menninger in Boorse, 1976, p. 69–70).

4. "Mental health, in the humanistic sense, is characterized by the ability to love and to create, by the emergence from the incestuous ties to family and nature, by a sense of identity based on one's experience of self as the subject and agent of one's powers, by the grasp of reality inside and outside of ourselves, that is by the development of objectivity and reason. . . . The Mentally healthy person is the person who lives by love, reason and faith, who respects life, his own and that of his fellow man" (Fromm, 1955).

5. ". . . here we have to deal with those persons who fall ill as soon as they pass beyond the irresponsible age of childhood, and thus never attain a phase of health — that of unrestricted capacity in general for production and enjoyment" (Freud equating mental health with his 'genital phase' of personality development, in Rickman, 1957, p. 66).

6. "True Sanity entails in one way or another the dissolution of the normal ego, that false self competently adjusted to our alienated social reality; the

emergence of the 'inner' archetypal mediators of divine power, and through this death a new kind of ego-functioning, the ego now being the servant of the divine, no longer its betrayer" (Laing, 1967).

Many wonderful things other than rational autonomy are mentioned in the foregoing imperialistic definitions of mental health, and we should realize that the judgment that they do not belong in such a definition is not by any means the same as the judgment that they are not wonderful! Nor is it the same as the judgment that we never need help and counseling in achieving these wonderful things. It simply recognizes that those who do such counseling should more honestly be termed applied axiologists, moral educators, spiritual mentors, political activists, etc. Szasz (1974, p. 262) has a point in condemning 'mental illness' as a myth *where values other than those of rationality and autonomy are involved* in the therapist-patient relationship. *Beyond that point*, psychotherapists are dealing with what he terms "personal, social, and ethical problems in living." *Up to that point*, however, they are dealing with real insanity, which Szasz fails to see. The rationally autonomous person may *choose for himself* just how much value he will attach to social conformity and adjustment, productivity, pleasure, heterosexuality, socially considerate behavior, love, faith, creativity, introspection, mysticism and all such good things. The rationally autonomous person may still need value education in such matters, and it may be a perfectly legitimate function of psychotherapists and mental hospitals to provide such, though not in the name of treating mental illness or under the guise of *medical* expertise.

We should acknowledge that two great and interrelated goods have been built into our very conception of sanity – rationality and autonomy. It is quite possible, however, to agree that these are great goods without agreeing upon precisely what kind of goods they are, and for most practical purposes it is not even necessary to agree upon the latter. Philosophers distinguish intrinsic goods, things worth having, experiencing, doing, preserving for their own sake from instrumental goods, things required for the actualization of other values beyond themselves. Are rationality and autonomy intrinsic ends in themselves? Are they merely indispensable means to other intrinsic goods such as enjoyment or long range happiness defined in terms of enjoyment? Is their actualization inherently enjoyable in itself, so that they become an integral part of our happiness, as John Stuart Mill suggested? We need not agree upon such

abstruse philosophical questions in order to agree that rationality and autonomy are great and indispensable human goods, and that life is so greatly impoverished that it merits the labels 'insanity' or 'mental illness' where these functions are significantly diminished.

Rationality and autonomy are controversial goods, not universally prized, however. Blind faith and obedience to external authority are greatly preferred by many (but not all) religious thinkers and by totalitarian political regimes everywhere. A well functioning democracy must be heavily populated by citizens exemplifying a significant degree of rational autonomy, and in that sense there is a political dimension to our definitions of mental health and mental illness. And though *we* may conceive of rational autonomy as the very essence of moral agency, we should not forget that many religious and non-democratic political perspectives regard rational autonomy with dismay and insist that *their* ideal moral agents renounce it, or better yet never develop it, for blind, unthinking, inherited or emotionally induced devotion to unquestioned authority. In Russia, it is the rationally autonomous person who is involuntarily institutionalized in mental hospitals! Thus, it may not be possible to separate *completely* the values of mental health as rational autonomy from *all* political, moral and religious values. We can separate them from *most* such values, i.e. all the others, however; and it is necessary in a democratic society so to do.

Finally, we should realize that the value dimensions of how we conceive of 'mental illness' and 'mental health' are relevant to the practice of medicine in a mental hospital. If a mental hospital declares (as one with which I am acquainted has done) that "The goal of the institute is to restore its patients to an optimum level of social, intellectual, emotional, and vocational functioning in the community," we need to ask whether this is a realistic goal and just what it implies practically for patients. My own view is that 'optimum' is much too strong a word to use here, just as 'complete' was much too strong in the World Health Organization definition of 'health.' As a general affirmation of charity toward all and malice toward none, such formulations have a legitimate place. But as an avowal of realistic goals, such a statement is surely too strong. *All* the institutional and social arrangements and efforts of society and all the energies of the individual are required for the *summum bonum*, whatever that might be conceived to be; and no medical institution should claim or aspire to have the power and the resources required for its achievement. Reaching the *summum bonum* should certainly

not be a prerequisite for discharge from such a hospital, for no one would ever be discharged! In that sense such a goal is not a realistic one, especially for involuntarily committed patients. It would be much more sensible for mental hospitals to aim at a restoration to minimal sanity in the present conservative sense of the term, i.e. a degree of rational autonomy which is minimally sufficient for 'making it' in society, recognizing that even this is relative to what any given society or functional segment thereof expects of its members and provides by way of support.

Although care for and cure of mental illness should be the primary functions of a mental hospital, they certainly need not be its sole legitimate functions, any more than the physical care for and cure of disease need be the sole legitimate function of general hospitals and other medical practitioners. Medical professionals both within and without mental hospitals may also willingly and legitimately accept the additional tasks of relieving and preventing pain even where there is no hope of a cure, of assisting in social adaptation, giving moral counsel, and even being religious mentors (chaplains have a place) if they find that their patients are willing to ask and pay voluntarily for such services, or that society is willing to provide such services for those who want them but cannot pay. My only concern is that they recognize and admit what they are doing and not confuse treating mental illness with every form of aiding in the pursuit of justice and happiness.

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