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Aubrey Lewis' Paper on Health as a Social Concept Reconsidered in the Light of Today*

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It was only after much hesitation that I accepted your flattering invitation to contribute to this meeting in commemoration of Aubrey Lewis. On the one hand, I have the natural diffidence of a layman amongst experts. But as against this, although we were of the same generation, I cannot but be moved by a feeling akin to filial piety towards one whose work I so greatly admired, and to whom I am indebted for so many personal acts of kindness and generosity as I have been to Aubrey Lewis. I hope, therefore, that since the latter emotion has prevailed you will think it fitting that I should ask you to look back, from the standpoint of nearly a quarter of a century later, at the impressive paper on *Health as a Social Concept* which Aubrey Lewis read to the British Sociological Association in 1953.

Compelled to use dualist language, as indeed we still are, Lewis was concerned with the problems of defining first physical and then mental health. At the outset he dismissed the WHO definition of health as a state of 'complete physical, mental and social well-being' as being as meaningless as it is comprehensive. In so doing he disowned any sympathy with the exaggerated claims of the Mental Health Movement which reached its ludicrous climax in the USA in the 1960s when Gerald Caplan† exhorted psychiatrists to carry their activities into 'such fields as education, welfare, recreation, urban planning, and religion' and to establish themselves as competent to 'give the politicians added understanding of the human needs of their members'. Even before Lewis's paper was published, Desmond Curran had made short work of this kind of nonsense in his Presidential Address ('Psychiatry Limited') to the Royal Society of Medicine, Section of Psychiatry, in 1951, while the *coup de grâce* was delivered by Henry Miller in a magazine article in 1970.‡

Almost inevitably, Lewis reached his own definition of health by way of its opposite—illness. This he identified as primarily a disturbance of an organ or system in relation to its norm, adding that when this disturbance upsets the integration or balance of the whole organism 'illness is certain'. In physical illness, the patient usually also feels subjective symptoms of pain or distress, although in some cases sophisticated methods of diagnosis may reveal the malfunctioning of the diseased organ before the patient is aware that anything is amiss.

But it is when these criteria are applied to the definition of mental illness that trouble starts. To Lewis the crucial question was whether mental illness can be recognized 'as physical disease often is, by the qualitatively altered function of some part of the total, by disturbance of thinking, for example, or disturbance of perception'. In some cases this question is readily answered in the affirmative, as when a person is regarded as ill because he suffers from delusions or hallucinations; but even then the line between the hallucination and the mystical vision is not easily drawn. Moreover, the part-functions of the mind are highly artificial

* Read at the Quarterly Meeting of the Royal College of Psychiatrists (Aubrey Lewis's Memorial Meeting), 18 November 1976.

† Caplan, G. *Principles of Preventive Psychiatry* (Tavistock Publications, 1964), pp 270, 64.

‡ In his reminder that 'a psychiatrist is one who treats disease with mental symptoms' and not one who 'prevents wars, cures anti-Semitism, offers to transform the normally abrasive relations between men into a tedium of stultifying harmony, is the ultimate authority on bringing up children or selecting managing directors—or misuses his jargon to pronounce on every issue of the day in an incessant series of television appearances'. 'The abuses of psychiatry', *Encounter*, 5 May 1970.

constructs. Their traditional classification into the cognitive, the affective and the conative, as Lewis points out, covers a variety of subdivisions—'such as perception, learning, thinking, remembering, feeling, emotion, motivation'. By what criterion do we judge if each of these is functioning healthily? Where is the 'norm' against which disturbance is to be measured? The function of the eye is to enable us to see, and if it fails in that its malfunction is unquestionable. Lewis does not develop the contrast in detail, but we might well ask how do we judge whether, say, the affective element in the mind is functioning properly? The habitual use of the word 'disturbance' in the psychiatric vocabulary seems to imply that a healthy emotional condition would be one of complete equanimity and serenity. Yet every man or woman who falls in love, every creative artist or social reformer normally experiences great emotional disturbance. Are they therefore to be stigmatized as mentally sick?

Even worse difficulties are in store when in attempting to apply Lewis's physical parallel to its mental counterpart, we pass from the concept of function of particular organs to 'the internal adjustment and balance of separate systems within the total organism'. Lewis has pronounced that 'When this regulatory or integrating function is disturbed' in the physical sphere, 'illness is certain', and that 'the physician therefore must concern himself not only with the evidence of normal structure and function in parts of the body but in its total working'.

At this point dualist language, about 'adjustment of functions within the organism' and 'adaptation of this integrated organism to its surroundings', becomes highly obscurantist. Developing Lewis' argument, we are driven to ask what, after all, is this 'mind' with the health of which we are so much concerned—especially when an allegedly sick patient indignantly denies that there is anything wrong with him? Moreover, even if the physical health of an organism depends on adaptation to its surroundings, any glib assumption that mental health depends on a similar adaptation of the mind to its physical or social environment founders on the double question of what is to be adapted to what?

On the one hand, adaptation to the social environment inevitably involves judgements of value. To illustrate Lewis' point here, we might quote the case of Bishop Huddleston, who after he had returned from many years of ministry in tropical Africa to a similar function in London, made a number of unfavourable comparisons between his former and later environments. Who would suggest that his reaction to Britain was evidence of his mental illness?

On the other hand, man has a unique capacity, not comparably shared by other animals, to modify both his physical and his social environment. If he finds himself socially maladapted, the fault may lie less in himself than in the social structure to which he is required to adjust himself but which he may be able to modify. Bishop Huddleston certainly tried to change his social environment by introducing into the Londoners' way of life some of the qualities and customs in which he found them lacking, but which he had admired in the Africans.

Once the issue of social adaptation is raised, the well-worn problem of psychopathy is bound to rear its tiresome head. Here the logic of Lewis' argument led him to the conclusion that 'for illness to be inferred, disorder of function must be detectable at a discrete or differentiated level that is hardly conceivable when mental activity as a whole is taken as the irreducible datum'; and this in turn prefaced his categorical declarations that 'if nonconformity can be detected only in total behaviour, while all the particular psychological functions seem unimpaired, health will be presumed, not illness'—and that 'the concept of disease—and of health—has physiological and psychological components, but no essential social ones'. In short, as Lewis put it, 'one can be sociopathic without being psychopathic', as indeed is admirably illustrated by the case of Bishop Huddleston just quoted.

These pronouncements, of course, not only ran counter to powerful trends in the thinking of many of Lewis' contemporaries, but are also in flat contradiction of Sir David Henderson's classic and no less categorical (1939) definition of psychopathy which ended with the words, 'The inadequacy or deviation or failure to

adjust to ordinary social life is not mere wilfulness or badness which can be threatened or thrashed out of the individual so involved, but constitutes *a true illness* [my italics] for which we have no explanation.'

The argument of Lewis' paper is highly condensed, and the task of condensing it still further, while interspersing a few comments of my own, has not been easy: I can only hope that I have not been guilty of any serious misrepresentation. I must now proceed to the second part of my task, which is to assess the measure in which Lewis' proposition that there are no essential social components in the concept of mental disease has been respected in practice, or in the subsequent trend of theory.

First, Lewis' paper has one significant omission. He had little to say on the subject of subnormality, but he did refer in passing to the importance of keeping the 'estimation of mental health clear of direct occupational and other social considerations . . . in order to avoid getting spuriously high correlations between morbidity and social adjustment'. However, six years had still to pass before the 1959 Mental Health Act wrote into the Statute Books its definition of severe subnormality, as 'an arrested or incomplete development of mind' 'of such a nature or degree that the patient is incapable of living an independent life or of guarding himself against serious exploitation'. The yardstick that measures the difference between the deficiency of intelligence that characterizes subnormality *per se* and the severe condition is thus purely social, based on the patient's ability to satisfy the demands of the society in which he finds himself. But that capacity is inextricably related to the state of the economy. As has often been pointed out,* the mental threshold at which a man or woman can hold down a job, resist exploitation, and lead to an independent life rises and falls with the fluctuations of the labour market. Even Tredgold, who regarded 'the social as not only the most logical and scientific concept of mental deficiency, but as the only criterion which the community can justly impose', was careful to add that 'ability to maintain an independent existence must be judged in relation to circumstances which normally obtain'.† But what in this context is 'normality'? When business is booming, employers will take on workers who would not stand a chance in an industrial depression when they must compete against a million and a half of (for the most part presumably normal) unemployed. Thus it is the instability of social conditions, not any change in the patient's condition as judged by any personal criterion, which elevates or depresses his mental categorization.

Next, I would call attention to two later contributions to the discussion of psychopathy, both of which appear strongly to reinforce Lewis's conclusions, though neither mentions his name. Of these the first is to be found in Nigel Walker's chapter on 'Psychopathy in the Sixties'‡ in his *Crime and Insanity*; and the second in the recent Report of the (Butler) Committee on Mentally Abnormal Offenders.¶

Walker finds psychopathy as a diagnostic label thoroughly unsatisfactory. It may, he admits, serve as shorthand for the statement that 'I may not be able to explain or treat this disorder, but I can tell you that the patient is going to go on behaving badly (unless of course he is kept in custody).' Nevertheless, to Walker the evidence that psychiatry can distinguish between psychopaths and mentally normal criminals is unconvincing; and in support of this thesis he quotes an investigation in which Trevor Gibbens followed up for eight years a group of imprisoned psychopaths selected as 'particularly severe cases', and matched them against a control group of presumably normal prisoners with similar criminal histories. Gibbens found 'disconcertingly little' difference in the reconvictions of the two groups; and he concluded that 'Whatever the prognosis of the psychopath may be in terms of his mental state, his criminal prognosis appears to be very uncertain and not

* See Lyons and Heaton Ward's Compilation, *Notes on Mental Deficiency* (Bristol: Wright, 1953).

† Tredgold, A. F. *A Textbook of Mental Deficiency* (Baillière, Tindall and Cox, 1952), pp 4, 5.

‡ Walker, Nigel and McCabe, Sarah. *Crime and Insanity in England*, Vol 2, New Solutions and New Problems (Edinburgh University Press, 1973), pp 232–6.

¶ Cmnd 6244 of 1975.

very different from that of any other man with the same number of criminal convictions.'*

Walker then himself initiated a further investigation to see whether a diagnosis of psychopathy might distinguish psychopaths not simply from 'ordinary' criminals but from other *mentally disordered* offenders, diagnosed as schizophrenics, manic-depressives or subnormals. Again no consistent differences were found, the psychopaths doing better than some categories of their mentally disordered companions, and worse than others, in respect of such criteria as subsequent reconvictions, employment records or readmission to hospital. All in all, the relationships were 'very weak'.

Walker's final conclusion is that the psychopathic label merely 'exaggerates the difference between those criminals' who wear it and those who don't; and that it has no prognostic, therapeutic or even explanatory value. Yet he did not propose 'to discredit completely the concept of behaviour disorders' but was merely sceptical as to whether these can all be subsumed under a 'single label with so disreputable a history'.

This condemnation was, however, subject to one remarkable concession. Disreputable though the history of the psychopathic label might be, psychiatrists, in Walker's view, indisputably 'seem to feel a need to use' it. Its retention, it appears, is therefore to be defended on the ground that it provides a psychiatrist with a ready-made ticket which would help him to 'get his patient through the customs barrier of the courts'. Accordingly Walker proposed that it should remain as 'a unique example of a pseudo-diagnosis for which legislators are partly, if unwittingly, responsible'.

(Does not this, incidentally, amount to implicit acceptance of the doctrine, expressly rejected by Lewis, that illness is what doctors treat?)

In its turn, the Butler Committee's wrestling with the problems of psychopathy led to some potentially radical conclusions for which, one suspects, Lewis might have had considerable sympathy. The Committee reported that the great weight of evidence presented to them supported the conclusion that psychopaths 'are not, in general, treatable, at least in medical terms': while a number of witnesses had further urged upon them that psychopathic disorder should be deleted from the Mental Health Act's definitions. This proposal was in particular supported on the ground that (as I have often argued myself) the concept of psychopathy is logically defective, inasmuch as it infers mental disorder from anti-social behaviour, while purporting to explain the anti-social behaviour by mental disorder—a criticism closely linked to Lewis' emphatic declaration that if nonconformity can be detected only in total behaviour, then health, and not illness, must be presumed. Other witnesses saw the concept of psychopathic disorder as part of the general attempt of a secular society to replace moral explanations of behaviour by medico-scientific explanations—thus apparently teetering on the brink of the doctrine that the medical profession should be the arbiters of our morals—an inference which I feel sure would have been as abhorrent to Lewis as it is to myself.

The Committee obviously hankered after the idea of dispensing with psychopathy as a legal category altogether; but as their terms of reference related only to *offenders* they could not make a recommendation to this effect, since it would necessarily have also been applicable to other persons classified as psychopaths who were not criminals: to have used different definitions in different parts of the same Act would have been manifestly absurd. In the end they solved the problem by recommending an amendment of the Mental Health Act, the radical implications of which seem to have passed unrecognized. This proposed to add to Sec. 60(i) of the Act (which allows the court to make hospital orders in the case of mentally disordered offenders) a provision that:

> 'no order shall be made under this section in the case of an offender suffering from psychopathic disorder with dangerous anti-social tendencies unless the court is satisfied:
>
> (a) that a previous mental or organic illness or an identifiable psychological or physical defect relevant to the disorder is known or suspected; and

* *Op cit.*, p 232.

(b) there is an expectation of therapeutic benefit from hospital admission.'

By the first of these provisions the Committee appear to have arrived at acceptance of Lewis' thesis that mental disorder must involve some disturbance of part-function, at least in the case of the dangerously anti-social offender. They could not say, as he did, that the alleged psychopath who was diagnosed solely by his 'total behaviour' and exhibited no symptoms of disordered mental 'part-functions' was not a sick man at all. To have done so would have put the dangerous offender (the appropriate treatment of whom was the main purpose of their appointment) outside their terms of reference, which were restricted to the mentally abnormal. They therefore retained the dangerously anti-social 'psychopath' in the mentally abnormal category, but excluded him from hospital treatment unless he also showed other symptoms of mental disorder. And to round the matter off they bravely declared that 'properly used, the prison environment can possibly provide the situation within which dangerous psychopaths can most readily be helped to develop more acceptable social attitudes'.

In practice, of course, it is already by no means unusual for a man diagnosed as a dangerous psychopath to be committed to prison, instead of being made the subject of a hospital order, sometimes because no hospital can be found that is willing to accept him, or, alternatively, because the sentencing judge is not satisfied that the security is adequate in any which is prepared to do so. But are not such committals a violation of the fundamental principle of British justice, which divides us all* into normal sheep who must be held responsible and therefore punishable for wrong-doing, and abnormal or mentally sick goats whom it would be immoral to punish, although, if their sickness is dangerous either to themselves or to others, it may be necessary to restrict their liberty? And does not the penal system (witness its name) exist to administer suitable punishment to the wicked, while the purpose of hospital and other medical services is to take care of the sick upon whom punishment must not be inflicted? In the days of capital punishment it might indeed have been argued that it would be more humane and more rational to execute some poor crazed creature who was unable to appreciate the enormity of what he had done, rather than to spare the life of one who had deliberately committed murder while in full possession of his faculties and who might live to repent and to make what amends he could.† Yet the law decreeed the opposite.‡ And even after the abolition of the death penalty the principle that punishment is morally right for the wicked and wrong for the mentally sick is still fundamental in our law.

Thus the Butler Committee, in recommending that 'dangerous psychopaths', the reality of whose mental disorder they had to accept, would in certain cases be more appropriately dealt with in prison than in hospital, have set the seal of approval on a practice which threatens to rock the principles of British justice to their foundations. Aubrey Lewis, on the other hand, reached exactly the same practical result without challenge to those principles, by merely shifting the boundary between the mentally healthy and the sick so as to exclude the so-called psychopath from the latter category.

Far be it from me to find fault with either of these courses! As I see it (and have often said before) the nice distinctions about criminal responsibility and mental abnormality required by law far outstrip what our knowledge enables us to draw; from which it follows that, pending the acquisition of more knowledge as to the meaning of normality, an investigation restricted to 'abnormal offenders' is either anachronistic or premature, though a study of

* Except for (since 1957) a half-way house of diminished responsibility in homicide cases only; and the now very rare cases of 'not guilty of murder by reason of insanity'.

† As did Nathan Leopold of the famous Leopold and Loeb murder case (New York, 1924). See his *Life Plus 99 Years* (Four Square Books Ltd, 1960).

‡ The most sickening application of this rule that I have ever come across occurred many years ago in Turkey, when after a *coup d'état* several former ministers were condemned to death. But when the day of execution arrived, it was officially announced that M. Menderes, the former Prime Minister, 'is not well enough to be hanged today'.

dangerously anti-social criminals in general might be timely. Meanwhile, the rigidities of the law notwithstanding, is there not much to be said for a pragmatic policy of allowing the distinction between the medical and the penal institution to become increasingly blurred until it is finally obliterated, as both merge into non-specific custodial establishments, catering, so far as our knowledge permits, for each according to his needs? In any case that, I suspect, is the destination towards which the separate routes followed by Aubrey Lewis, Nigel Walker, and most recently by the Butler Committee are inevitably leading.

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