University of Pennsylvania
Law Review

FOUNDED 1852

Formerly
American Law Register

VOL. 111 FEBRUARY, 1963 No. 4

"MENTAL DISEASE": THE GROUNDWORK FOR LEGAL ANALYSIS AND LEGISLATIVE ACTION

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Mental health and *mental disease* are concepts of great importance to the twentieth-century legislator. The content and meaning of these terms are also matters of concern to judges and attorneys, who at one time or another must deal with persons suspected of having marked psychiatric difficulties.

In providing for civil commitment, a New York statute defines a "mentally ill person" as "any person afflicted with *mental disease* to such an extent that for his own welfare or the welfare of others, or of the community, he requires care and treatment." [1] Similarly, the Federal Security Agency's Draft Act Governing Hospitalization of the Mentally Ill defines a "mentally ill individual" as "an individual having a psychiatric or other disease which substantially impairs his *mental health*." [2] Obviously, these statutes cannot be administered without reference to some further definition of *mental disease* and *mental health*.

The same concepts are also relevant to criminal law. The concept of *mental disease* is a universal element in tests of criminal responsibility. The *McNaughten* rule,[3] the prototype of tests used in the

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1 N.Y. MENTAL HYGIENE LAW § 2(8). (Emphasis added.)

2 U.S. FEDERAL SECURITY AGENCY, A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL § 1(a) (rev. ed. 1952). (Emphasis added.)

3 McNaughten's Case, 10 Cl. & F. 200, 8 Eng. Rep. 718 (H.L. 1843).

majority of American states,[4] provides that "to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from *disease of the mind,* as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong." [5] More recently, the Court of Appeals for the District of Columbia Circuit held [6] that "an accused is not criminally responsible if his unlawful act was the product of *mental disease* or mental defect." [7] The term *mental disease* is also used in the Model Penal Code:

> Section 4.01. Mental Disease or Defect Excluding Responsibility.
>
> (1) A person is not responsible for criminal conduct if at the time of such conduct as a result of *mental disease* or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.
>
> (2) As used in this Article, the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct.[8]

One writer has stated the modern trend to be that "the concept of illness expands continually at the expense of the concept of moral failure." [9] To the extent that this is true, there is every reason to believe that broader and more diverse measures of compulsory treatment will be provided for in legislative enactment. Even those jurists who doubt the justice of punishing the ill, are convinced that, under appropriate circumstances, it is proper to compel those reclassified as sick to undergo treatment.

This proposition is forcefully illustrated by the Supreme Court's recent decision in *Robinson v. California*.[10] The Court there held that a California statute making narcotic addiction a crime [11] violated the

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4 See MODEL PENAL CODE § 4.01, appendix A (Tent. Draft No. 4, 1955).

5 10 Cl. & F. 200, 209, 8 Eng. Rep. 718, 722 (H.L. 1843). (Emphasis added.)

6 Durham v. United States, 214 F.2d 862 (D.C. Cir. 1954).

7 *Id.* at 874-75. (Emphasis added.)

8 MODEL PENAL CODE § 4.01 (Proposed Official Draft 1962). (Emphasis added.)

9 Wootton, *Sickness or Sin?*, 159 TWENTIETH CENTURY 433, 434 (1956). See also Gruenberg & Bellin, *The Impact of Mental Disease on Society*, in LEIGHTON, CLAUSEN & WILSON, EXPLORATIONS IN SOCIAL PSYCHIATRY 341, 356-57 (1957): "This extension of the concept of mental disorder accompanies an erosion of more traditional values. Misbehavior tends to be regarded more as bad health than as wrong."

10 370 U.S. 660 (1962), *rehearing denied, petition for abatement of judgment as moot denied,* 31 U.S.L. WEEK 3165 (U.S. Nov. 13, 1962), 111 U. PA. L. REV. 122.

11 CAL. HEALTH & SAFETY CODE § 11721, under which the defendant had been convicted, made it a misdemeanor, punishable in no case by less than 90 days in jail, "to be addicted to the use of narcotics."

fourteenth amendment prohibition of cruel and unusual punishment. Although narcotic addiction most often involves an initial choice to take drugs which many would find blameworthy,[12] the Court held that it was a disease, in itself no more punishable than the "crime" of having a common cold.[13] But the Court also recognized that its decision did not insulate the defendant from all compulsory measures. In fact, the majority and concurring opinions expressed approval of involuntary commitment predicated on treatment, rather than punishment, of the defendant's addiction to narcotics.[14]

If this approach is to be successful, however, there must be adequate legislation dealing with civil commitment. And if there is to be new legislation, seemingly well defined terminology must be reevaluated to determine its proper meaning in this new context.

One legal commentator has argued that "mental illness is a medical concept, and so it would seem self-evident that its definition should come from the medical profession and not from either legislators or judges."[15] Lawyers and legislators may find this proposal superficially appealing. Like other nonmedical men, they are inclined to think of *mental disease* and *mental health* as scientific terms. The fact is, however, that psychiatrists, as they use those terms, have not provided society with instruments of rational discussion. To a large degree, the meaning of *mental disease* is personal to each practitioner. It is no secret that there is considerable disagreement in contemporary

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[12] Mr. Justice Stewart, however, emphasized the possibility that addiction might be innocently incurred. "Not only may addiction innocently result from the use of medically prescribed narcotics, but a person may even be a narcotics addict from the moment of his birth. [Citing medical references]" 370 U.S. at 667 n.9. Mr. Justice Douglas made the same point, citing and quoting a newspaper account of medical observations. "The first step toward addiction may be as innocent as a boy's puff on a cigarette in an alleyway. It may come from medical prescriptions. Addiction may even be present at birth." 370 U.S. at 670 (concurring opinion).

[13] 370 U.S. at 667.

[14] "[A] State might establish a program of compulsory treatment for those addicted to narcotics. [Footnote by the Court: California appears to have established just such a program in §§ 5350-5361 of its Welfare and Institutions Code. The record contains no explanation of why the civil procedures authorized by this legislation were not utilized in the present case.] Such a program of treatment might require periods of involuntary confinement." 370 U.S. at 665 (majority opinion). "The addict is a sick person. He may, of course, be confined for treatment or for the protection of society." 370 U.S. at 676 (Douglas, J., concurring).

For further discussion of the *Robinson* case, see notes 74-78 *infra* and accompanying text.

[15] Weihofen, *The Definition of Mental Illness*, 21 OHIO ST. L.J. 1 (1960). Later in the same article, Weihofen criticizes subsection 2 of § 4.01 of the Model Penal Code. *Id.* at 6-7. The version of § 4.01 in the Official Draft of the Code, adopted by the American Law Institute in 1962, is set forth in the text accompanying note 8 *supra*. That formulation is with two modifications the same as the one published in Tentative Draft No. 4 (1955), to which Professor Weihofen responded: (1) in subsection 1 the bracketed word "wrongfulness" was inserted after "criminality," to indicate an option in the choice of words; and (2) the words "As used in this Article" were added at the beginning of subsection (2).

For another reaction to § 4.01(2), see WILLIAMS, CRIMINAL LAW—THE GENERAL PART 536 (2d ed. 1961).

psychiatry about many things, including the classification of psychological conditions exhibited by patients.[16] This disagreement is both terminological and conceptual, and not merely a result of present limitations in scientific knowledge. Moreover, apart from their participation in legal proceedings, psychiatrists are not accustomed to thinking in terms of whether an individual's condition should be classified as *mental disease*; they are more concerned whether the condition of the individual examined fits into some diagnostic category, which is not the same thing.

For legal purposes, however, there is an even more important reason to scrutinize carefully medical definitions of *mental disease*. Any definition of *mental disease* will involve value choices on questions of social philosophy. But in a legal context, this concept can be and is used as a basis for classification; it is a device by which to determine the applicability of measures of involuntary detention, care, and treatment. When decisions between competing values will broadly affect society, they are clearly matters of public rather than purely professional concern.

Therefore, this Article is directed particularly to the legislator who may have to draft or vote upon proposed legislation dealing with civil commitment, criminal responsibility, and conduct to be proscribed by the criminal law. It is important that legislators have available a systematic analysis of the concepts *mental disease* and *mental health*, and the systems of classification which are based upon them.[17] Legislatures

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[16]
> Everybody who has followed the literature and listened to discussions concerning mental illness soon discovers that psychiatrists, even those apparently sharing the same basic orientation, often do not speak the same language. They either use different terms for the same concepts, or the same term for different concepts, usually without being aware of it. It is sometimes argued that this is inevitable in the present state of psychiatric knowledge, but it is doubtful whether this is a valid excuse.

Stengel, *Classification of Mental Disorders*, 21 BULL. WORLD HEALTH ORGANIZATION 601 (1959).

[17] When Sir James F. Stephen inquired into the "relation of madness to crime," he found it necessary to attempt to answer the questions "What is the meaning of the word mind?" and "What is a sane and what an insane mind?" 2 STEPHEN, HISTORY OF THE CRIMINAL LAW OF ENGLAND 128 (1883). Concerning the bearing of such questions on the subject of criminal responsibility, he wrote: "Difficult and remote from law as some of these inquiries may be, it is impossible to deal with the subject at all without entering to some extent upon each of them." *Id.* at 129. The following are Stephen's definitions of *sanity* and *insanity*, which he based on a reading of medical works of his time:

> What are sanity and insanity?
>
> The answer is, that sanity exists when the brain and the nervous system are in such a condition that the mental functions of feeling and knowing, emotion, and willing, can be performed in their regular and usual manner. Insanity means a state in which one or more of the above-named mental functions is performed in an abnormal manner or not performed at all by reason of some disease of the brain or nervous system.

Id. at 130.

ought to be made aware that the concept of *mental disease* is a nonlegal means of classification, which must be modified for legal purposes. Modifications may be based on statutes, precedent, and, most important, on policy considerations relevant to a particular context.

To this end, I shall attempt to develop a reasoned analysis for defining and classifying *health* and *disease*. Once the definitional elements involved are articulated, choices—for legal purposes—may more rationally be made between conflicting concepts of *mental health* and *mental disease*.

I. Redefinition of Mental Disease and Mental Health

A. Present Usage

1. The "Social Definition"

The medical profession is not the only source of current definitions of *disease*. The lay members of any society have numerous attitudes and beliefs concerning what constitutes *disease*, the moral and empirical content of that concept,[18] and how people should respond in their actions and feelings to those who are ill.[19] Collectively, these opinions make up a body of social norms.[20]

In fact, there is constant interaction between the medical and social concepts of *disease*. The idea of *disease* exists in the minds of doctors

18 See, *e.g.*, Firth, *Acculturation in Relation to Concepts of Health and Disease*, in Galdston, Medicine and Anthropology 129, 140 (N.Y. Academy of Medicine Lectures to the Laity No. 21, 1959).

19 The socially institutionalized expectations of others with respect to the sick person, which tend also to be his expectations of himself, have been termed the "sick role."

> There seem to be four aspects of the institutionalized expectation system relative to the sick role. First, is the exemption from normal social role responsibilities, which of course is relative to the nature and severity of the illness. . . .
>
> The second closely related aspect is the institutionalized definition that the sick person cannot be expected by "pulling himself together" to get well by an act of decision or will. In this sense also he is exempted from responsibility—he is in a condition that must "be taken care of." His "condition" must be changed, not merely his "attitude." Of course the process of recovery may be spontaneous but while the illness lasts he can't "help it." . . .
>
> The third element is the definition of the state of being ill as itself undesirable with its obligation to want to "get well." . . .
>
> Finally, the fourth closely related element is the obligation—in proportion to the severity of the condition, of course—to seek *technically competent* help, namely, in the most usual case, that of a physician and to *cooperate* with him in the process of trying to get well. . . .

Parsons, The Social System 436-37 (1951).

20 For further discussion of various aspects of the social definition of *mental disease*, see Davis, Human Society 257-59 (1949); Landis & Page, Modern Society and Mental Disease 8-10 (1938); Parsons, *Illness and the Role of the Physician: A Sociological Perspective*, 21 Am. J. Orthopsychiatry 452, 456-57 (1951); Woodward, *Changing Ideas on Mental Illness and Its Treatment*, 16 Am. Sociological Rev. 443 (1951).

as an imprecise mental composite of various particular experiences gained in medical training and practice. To some extent, these experiences will reflect the social norms of the society in which the doctor practices. But as the profession collects and synthesizes the diverse elements in its experience, it exerts a reciprocal influence on the very norms from which it draws.[21]

2. The State of Professional Usage

Current medical definitions of *mental disease* present both terminological and conceptual problems. Doctors employ many words which seem to have similar meanings—disease, disorder, disturbance, ill health, illness, reaction, sickness, and syndrome.[22] But few have attempted either to relate the general meaning of those terms, or to explain the similarities and differences between them.

Members of the medical profession are aware that their terminology is imprecise. One writer in a psychiatric journal—though not himself a medical doctor—pointed this out in discussing normality, mental health, and diagnostic decisions:

> "Normality" is a highly personal concept. No generally accepted norms exist. Mental health is whatever the practitioner thinks it is. Usually the technicians cannot verbally or operationally define the concept on which their judgments are based. "We have had years of experience," or "It is our clinical judgment," might be their explanation. Many important diagnostic decisions in courts, hospitals, schools, and private practices, which have a vital influence on the lives of individuals, are made on the basis of such personal standards.[23]

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21 These ideas, the health and illness aspect of a culture, are never the sole possession and certainly never the exclusive creation of those who devote themselves to the healing arts. On the other hand, the medical culture of the dominant healing profession (or professions, for they are not so united in all as in our own culture) never coincides exactly with that of the lay world.

Hughes, *The Making of a Physician—General Statement of Ideas and Problems*, 14 HUMAN ORGANIZATION 21 (Winter 1956).

22 In this Article the word *mental* is used as a qualifying adjective, *i.e., mental disease*. In recent medical usage there seems to be some increased tendency to use *psychiatric disorder* as the generic term. This term is vague, because the interests and activities of psychiatrists vary widely, but the word *psychiatric* is inclusive and circumvents controversy. By retreating from the subject matter to the professional group which studies it, the term does seem to work at least a tactical improvement over the confusion resulting from variations and changing fashions in generic labels, including *mental* disorders, *nervous* disorders, *personality* disorders, and *behavior* disorders.

23 Eaton, *The Assessment of Mental Health*, 108 AM. J. PSYCHIATRY 81, 84 (1951). See also Lewis, *Health as a Social Concept*, 4 BRIT. J. SOCIOLOGY 109 (1953); Marzolf, *The Disease Concept in Psychology*, 54 PSYCHOLOGICAL REV. 211, 214 (1947); Redlich, in MILBANK MEMORIAL FUND, INTERRELATIONS BETWEEN THE SOCIAL ENVIRONMENT AND PSYCHIATRIC DISORDERS 118, 120 (1953); see text accompanying note 86 *infra*; Scott, *Research Definitions of Mental Health and Mental Illness*, 55 PSYCHOLOGICAL BULL. 29 (1958).

This does not mean, however, that there is no area of agreement among doctors. Formalized training and certain clinical tools, such as psychological tests and psychometric measurements, do produce some uniformity. As a result, certain very basic concepts are almost universally accepted. But the large fringe area remains uncertain.

> The concept of mental disease is well-defined and beyond controversial interpretation only in a central core of the concept, *i.e.*, with regard to such conditions in which the sense of reality is crudely impaired, and inaccessible to the corrective influence of experience—for example, when people are confused or disoriented or suffer from hallucinations or delusions. . . .
>
> But outside of this inner core, there is a vast fringe area of conditions which may, or may not, be considered to be diseases of the mind. Are psychopathies, psychoneuroses (like kleptomania) or perversions (like exhibitionism) diseases of the mind? The definition of the term becomes arbitrary, and the above questions will be answered differently by different psychiatrists. *Whether or not a psychiatrist is willing to classify any one of these conditions as diseases of the mind depends more on his philosophy than on any factual question that can be settled by observation and reasoning.*[24]

This uncertainty within the medical profession limits the usefulness of its terminology and definitions to the legislator. Nor is there any sign that more precision and agreement are forthcoming. As one commentator has put it: "The concept of health is important to all clinical specialties including psychiatry, but the subject seldom receives much serious thought." [25]

3. The Usefulness of Implicit Social and Medical Definitions

From the special point of view of the medical profession, the concept of *disease* provides mental guidelines serving several useful purposes. It helps doctors to determine who needs treatment and care. It also aids in the formulation of sub-concepts defining standards of normality for particular activities included within the larger framework of human endeavors. In addition, the concept of *disease* is a useful tool

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[24] Waelder, *Psychiatry and the Problem of Criminal Responsibility*, 101 U. PA. L. REV. 378, 384 (1952). (Emphasis added.)

[25] Redlich, *The Concept of Health in Psychiatry*, in LEIGHTON, CLAUSEN & WILSON, EXPLORATIONS IN SOCIAL PSYCHIATRY 138, 139 (1957). "In clinical medicine, the terms 'normal' and 'healthy' are used interchangeably." *Ibid.* "Mental health, as a scientific concept, does not now exist." *Id.* at 143. See Eaton, *The Assessment of Mental Health*, 108 AM. J. PSYCHIATRY 81 (1951). See generally EVALUATION IN MENTAL HEALTH (U.S. Public Health Service Pub. No. 413, 1955).

in the study of the interaction between the individual, his physical environment, and the social setting, which in turn, may yield information leading to the establishment of programs of disease prevention.

For society as a whole, *disease* is an even more basic concept. If refined and clarified, it can be a highly useful device for identifying and distinguishing between various kinds of human problems—between value questions and other controversies with which man must be concerned. It can enable us to characterize what we choose to mean by "success" (health) and "non-success" (disease) as related to specific problems. The distinction between *health* and *disease* is a means of identifying a problem, communicating about it, and ultimately taking concerted action against all of its manifestations.[26]

Not everything wrong with man, however, can usefully be classified as *disease.* Poverty, ignorance, crime, self-righteousness, and indifference may at times be evidence of disease; but none of them in itself can usefully be so classified. To include them within the concept of *disease* would only lead to confusion and reduce the effectiveness of efforts to deal with each properly.

B. Redefinition and Classification

In order to analyze rationally the concepts *mental health* and *mental disease,* it is first necessary to redefine them.[27] The definition offered in this Article is not, however, a total departure from traditional usage; it draws heavily on existing medical and psychological sources.[28] But it does reject certain elements which have produced confusion. In this respect, it is a stipulative definition—one by which the author gives his own meaning for a word—rather than a lexical definition in which the author reports the meaning of a word as it is actually used.[29]

Clarification of the concepts *mental health* and *mental disease* is fraught with practical and theoretical difficulties. Redefinition must take place at a level of abstraction rather far removed from work-a-day interests and needs. While a gap between scientific analysis and prac-

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26 "[B]oth, health and disease, remain conceptions or ideas conceived with the purpose of bringing system and order into facts unrelated in themselves, conceived, above all, with the intention of outlining a plan of action which would lack coherence were it directed towards the isolated facts themselves and not towards their integrated totality." RIESE, THE CONCEPTION OF DISEASE 97 (1953).

27 See ROBINSON, DEFINITION 66-72, 187 (1950).

28 See Seguin, *The Concept of Disease,* 8 PSYCHOSOMATIC MEDICINE 252, 256 (1946); Lewis, *supra* note 23, at 117. See also OXFORD ENGLISH DICTIONARY (1933); WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY (unabridged ed. 1961).

29 See ROBINSON, *op. cit. supra* note 27, at 11.

tical demands is common in many fields of study, and in some is of no real importance, medicine and law are applied disciplines, dominated by the viewpoint of practitioners rather than researchers. The attempted definition, therefore, will appear to some to be overly academic and philosophical. But an attempt will be made later to demonstrate that the degree of abstraction is not as great as may first appear.

1. Proposed Definitions

Mental Disease: Any reaction of the organism, to external and internal conditions, involving abnormality.

Abnormality: Any mode of any functions of the mind involving a stated degree of pain or danger of death.

Mental Health: Any reaction of the organism, to external and internal conditions, involving normality.

Normality: Any mode of each of the functions of the mind involving less than a stated degree of pain and danger of death.

Functions of the Mind (mental functions) are not here defined in general terms, but illustratively, by partial enumeration. (a) perceiving, (b) learning, (c) thinking, (d) remembering, (e) feeling, etc.[30]

2. Mental Disease and Mental Disorder

In present medical usage, a distinction is frequently made between *disease* and *disorder*. One definition of psychosis states that: "It is not considered in keeping with the available facts to refer to a psychosis as a disease, since the term *disease* is traditionally identified with pathology of tissues. For want of a better term psychiatrists speak of mental *disorder* when they refer to pathology of the psyche." [31]

However, in my view, *disease* in the generic sense should have no etiological connotations, whether by reference to structural or functional causation. The concept of *disease* is a theoretical or logical construct which is not demonstrably valid or invalid, whereas etiology is subject to empirical verification. It is important, therefore to distinguish between what is meant by *mental disease*, and how its occur-

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[30] Lewis, *supra* note 23, at 118.

[31] HINSIE & CAMPBELL, PSYCHIATRIC DICTIONARY (3d ed. 1960). On the disease-disorder distinction, see also *Diseases of the Psychobiologic Unit*, in AMA, STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS 85-92, 486-88 (4th ed. Plunkett & Hayden 1952), reprinted in AMERICAN PSYCHIATRIC ASS'N COMM. ON NOMENCLATURE AND STATISTICS, DIAGNOSTIC AND STATISTICAL MANUAL—MENTAL DISORDERS (1952). This nomenclature of the American Medical Association and the American Psychiatric Association—often referred to as "the Standard"—does not use the term *mental disease*, but refers to *diseases of the psychobiologic unit* as *mental disorders*, and subclassifies such *disorders* into various *syndromes* and *reactions*.

rence is explained. Schizophrenia is no less a *mental disease* because its etiology cannot be stated. The proposed definition, therefore, rejects the distinction between *disease* and *disorder,* and uses the former.

3. Mental Disease and Bodily Disease

Because of the paucity of data, it is more difficult to study *mental disease* than physical illness. Present understanding of *mental disease* is based on studies of hospital and private patients who present themselves for psychotherapy.[32] Both the sample and those who investigate it may be biased. Also, *mental disease* is sometimes expanded to include total behavior or conduct, whereas *bodily disease* is usually regarded as involving subdivisions of functioning.[33] For these reasons, it has been urged that the two should be studied separately.

For purposes of definition and classification, however, a distinction between *mental* and *bodily disease* is unnecessary. Both present the same theoretical problems and involve the same principles.[34]

4. Disease Patterns

Mental disease can be subdivided into disease patterns, "a pattern of factors which somehow hang together and recur more or less the same, in successive individuals." [35] It is at this level of specificity that many practitioners, including psychiatrists, become most interested in classifications.[36] But because of limited empirical knowledge and ex-

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[32] LEIGHTON, CLAUSEN & WILSON, EXPLORATIONS IN SOCIAL PSYCHIATRY 3 (1957); Redlich, *supra* note 25, at 143. See also Ruesch, *Communication and Mental Illness: A Psychiatric Approach*, in RUESCH & BATESON, COMMUNICATION 50, 71 (1951).

[33] See text accompanying notes 51-61 *infra.*

[34] Lewis, *supra* note 23, at 124 (1953). *But see* Redlich, in MILBANK MEMORIAL FUND, EPIDEMIOLOGY OF MENTAL DISORDER 94 (1950); Romano, *id.* at 60. See also text accompanying note 39 *infra.*

[35] King, *What Is Disease?*, 21 PHILOSOPHY OF SCIENCE 193, 197 (1954).

[36] *But see* Reid, *Logical Analysis*, 114 AM. J. PSYCHIATRY 397, 400 (1957):

> Some clinicians, to be sure, worry little about such dilemmas [of classification]. Long accustomed, perhaps, to the fog they work in, they have learned somehow . . . to "muddle through." Since they believe that very little follows, as regards prognosis or treatment, from applying most of the standard diagnostic terms to a given patient, their relaxing motto seems to be, "Why bother?" What is needed rather, they declare, is increasingly better descriptions (which are often clearer when couched in colloquial language) of individual patients, their relevant histories and current behaviors, *not* more allegedly precise definitions, since the so-called precision is largely illusory and futile anyway. So away with rigid definitional constraints on our free imagination, lest we become prisoners in our own verbal strait jackets!

For a brief historical note on attitudes towards classification in psychiatry, see Stengel, *Classification of Mental Disorders*, 21 BULL. WORLD HEALTH ORGANIZATION 601, 602-03 (1959). See also PLUNKETT & GORDON, EPIDEMIOLOGY AND MENTAL ILLNESS 18-27 (Joint Comm'n on Mental Illness and Health Monograph Series No. 6, 1960).

cessive expectations,[37] attempts at detailed classification are destinea to run into difficulty. No attempt will be made here, therefore, to deal with subcategories of *mental disease.*

5. The Treatment Criterion and the Nomenclature Criterion

It is sometimes suggested that the meaning of *disease* should be related to treatment. At any given time and place, persons classified as ill would be those who are actually being treated by physicians [38] or who, according to the prevailing social or professional norms, ought to be treated by a physician. Every proponent of this approach, however, has left the meaning of treatment unexplained, perhaps because any such definition inevitably becomes circular. Who is ill? Those persons who ought to be treated. But who ought to be treated? The proponents of the treatment criterion can only respond: Those persons who are ill.

The treatment criterion opens up other more complex questions. What is treatment? Who ought to be treated? What should be the goal of treatment? When should treatment be terminated?

The word *treatment* is as vague as the word *education.* It stands in a somewhat similar relation to *disease* and *health* as *education* does to *ignorance* and *knowledge.* The goal of education is often more than the mere imparting of knowledge; it may be the development of various skills, and mental and personal qualities. Similarly, treatment may do more than lead to health. It may be instrumental in cultivating other modes of functioning.

In their well known study of mental disease in New Haven, Connecticut, Hollingshead and Redlich stated, as one of the assumptions of their study, that:

> [M]ental illness is defined socially; that is, whatever a psychiatrist treats or is expected to treat must be viewed as mental illness. This position is based upon the fact that in

[37] See generally Reid, *Logical Analysis,* 114 AM. J. PSYCHIATRY 397, 401 (1957):

> [I]n the popular language of William James, what is the "cash value" of our nosological categories? What are they supposed to do for us? Some psychiatrists demand a good deal of them, it seems to me. For a common opinion is that a diagnostic class-term should not only enable us to label a disorder clearly, but that it should reveal—that is, plainly imply—the true "nature" of the disorder, and also indicate its cause, or causes, and finally point the way to its cure, or at least amelioration, by suggesting, even if it does not explicitly state, what methods to employ in treating it. This is a large order, and even if some doctors do order it, no one can deliver the goods.

[38] "Nearly 90 per cent of mental illness escapes recognition and, consequently, any possibility of treatment, control, or prevention." PLUNKETT & GORDON, EPIDEMIOLOGY AND MENTAL ILLNESS 5 (Joint Comm'n on Mental Illness and Health Monograph Series No. 6, 1960). "Because the treated rate is dominated by the availability and caliber of treatment facilities and by the attitudes of the individual and the community toward mental illness and treatment, it is a poor index of prevalence." *Id.* at 38. "Not all severe cases are treated, of course." *Id.* at 42.

> our society psychiatrists treat individuals whose behavior would be ignored in a second society, punished by the criminal courts in a third, and in still others given over to priests.[39]

This formulation of the treatment criterion does not explicitly state whose norms as to who ought to be treated are to prevail when there is disagreement between laymen and psychiatrists, or among psychiatrists themselves. Nor is the reason advanced for adopting the treatment approach persuasive. Differential social treatment or lack of treatment is not peculiar to mental disease; it is also found in physical illness. It does not seem useful to say that merely because a certain society or social sub-group believes that a condition which we regard as physical illness should be ignored or handled by priests, that we should so regard it. The same is true of mental disease, even though there may be wider disagreement as to its manifestations. The treatment criterion and other unrevised social definitions of disease would be acceptable only if there were no sound reason to disagree with local judgments concerning what is disease.

The treatment criterion is further confused by overlapping of professional activity.

> In community psychiatry, especially in the children's field . . . the psychiatrist is involved in matters in which other professional people in the community have an interest. For instance, educators are working constantly with children with reading difficulties. Many of these children are now being seen by psychiatrists. Are only those seeing psychiatrists psychiatric "cases"? It is very difficult to tell "what is a case" when various communities use many different resources for handling, for instance, reading difficulties.[40]

Overlapping professional activity is also common to the treatment of adult offenders, juvenile delinquents, persons with marital difficulties, those who have problems of vocational adjustment, and many others.

The nomenclature criterion of disease is a variant of the treatment criterion. Its proponents argue that *mental disease* should be defined as that which comes within the classificatory system of accepted psychiatric nomenclature, such as is found in the *Standard Nomenclature of Diseases and Operations*.[41] But again the definition is circular. What

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[39] HOLLINGSHEAD & REDLICH, SOCIAL CLASS AND MENTAL ILLNESS 11 (1958).

[40] Vaughan, in MILBANK MEMORIAL FUND, INTERRELATIONS BETWEEN THE SOCIAL ENVIRONMENT AND PSYCHIATRIC DISORDERS 136 (1953).

[41] *Diseases of the Psychobiologic Unit*, in AMA, STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS 85-92, 786-88 (4th ed. Plunkett & Hayden 1952), reprinted in AMERICAN PSYCHIATRIC ASS'N COMM. ON NOMENCLATURE AND STATISTICS, DIAGNOSTIC AND STATISTICAL MANUAL—MENTAL DISORDERS (1952).

should be included in psychiatric nomenclature? The only answer is *mental disease.*

It is possible to view psychiatric nomenclature as providing a useful and exhaustive system by which to classify, at a workable level of abstraction, all of the reasons for which individuals may be referred or refer themselves to a psychiatrist.[42] But the categories employed must be so broad that they will enable psychiatrists to label the problem of every person who seeks their help.

> Children who steal or have violent tempers or who wet their beds; men and women who cannot get on with their spouses or manage their love affairs satisfactorily; criminals convicted of various offences, as well as the victims of all manner of irrational fears, anxieties and depressions (and sometimes also of quite rational ones)—all these are to-day liable to be referred, or to refer themselves, to the psychiatric doctor.[43]

The importance of a system of nomenclature to psychiatrists should not be underestimated. It provides an important means whereby doctors can communicate among themselves in seeking proper solutions. But nonlegal definitions of *disease* cannot be used for legal purposes without scrutiny and quite possibly some modification. This is particularly true of a definition that assumes that those laymen who seek psychiatric help have such a sound idea of the meaning of *mental disease* themselves that the rest of society can rely upon it.

6. Process and Evaluation

a. Disease and Health Process

The theoretical or logical constructs *disease* and *health* have both empirical and normative elements. *Process* is their empirical aspect—a description and explanation of what is going on in the organism under observation. *Normality* and *abnormality,* on the other hand,

42 This point apparently has not been explicitly developed in the literature, but the need for extensive, uniform systems of labelling is well recognized. Quoting a passage from 1 WORLD HEALTH ORGANIZATION, MANUAL OF THE INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES, INJURIES AND CAUSES OF DEATH Introduction (1957), Stengel says: "[A] nomenclature, being 'a list or catalogue of approved terms for describing and recording clinical and pathological observations,' has to be *extensive and unlimited in scope* and detail to allow for the recording of the manifold varieties of ill health." Stengel, *Classification of Mental Disorders,* 21 BULL. WORLD HEALTH ORGANIZATION 601, 616 (1959). (Emphasis added.) See also AMERICAN PSYCHIATRIC ASS'N COMM. ON NOMENCLATURE AND STATISTICS, DIAGNOSTIC AND STATISTICAL MANUAL—MENTAL DISORDERS, at vi, 88 (1952). It is often assumed, however, that anything that can be given a label is an instance of abnormality, disease, disorder, morbidity, etc. *Id.* at vi; Ruesch, *Communication and Mental Illness: A Psychiatric Approach,* in RUESCH & BATESON, COMMUNICATION 50, 71 (1951).

43 Wootton, *Sickness or Sin?,* 159 TWENTIETH CENTURY 433 (1956).

while somewhat empirical, are the normative element—an evaluation of what is going on.

The proposed definition does not distinguish *disease* from *health* on the basis of the process involved in particular functioning. Interaction with the environment, lawfulness, the temporal dimension, and changes in functions along a continuum of degrees of pain and danger of death are characteristics of both.

b. Lawfulness

Despite earlier controversy, it is now generally accepted that although phenomena are classified as abnormal, they can still be lawful. "[P]athological phenomena can be recognized as . . . lawful variations of the normal life process." [44]

c. Sequence of Events

Disease is not static, but rather a sequence of states or events. Its temporal or historical dimension is basic.[45] In fact, the temporal dimension is essential to life, whether the individual's functions are classified as healthy or diseased.

d. Change

A living organism, whether healthy or diseased, is never in a wholly static condition. Life itself implies change. What is meant by change with reference to *disease*, therefore, must be other than, or in addition to, movement along some postulated normal life-line of growth, maturation, aging, and other normal cyclical changes. It refers to alterations in the modes of functioning along a continuum of pain and danger of death.

The theory of heredity—that the genetic endowment of an organism is fixed—does not detract from the importance of change.

> In defining the concept of *heredity* . . . one must remember that there is no inheritance of fully developed characters or anomalies, but only a transmission of *predispositions*, that is, of specific potential responses to the environment . . . . [Thus] we define heredity as "*the transmission of potential physical and mental properties . . . through genes.*" [46]

Change, therefore, involves a shift from potential to actual abnormality.

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[44] GOLDSTEIN, THE ORGANISM 10 (1939).

[45] Riese, *History and Principles of Classification of Nervous Diseases*, 18 BULL. OF THE HISTORY OF MEDICINE 465, 494-95 (1945). See also RIESE, THE CONCEPTION OF DISEASE 89 (1953).

[46] Kallmann, *Modern Concepts of Genetics in Relation to Mental Health and Abnormal Personality Development*, 21 PSYCHIATRIC QUART. 535, 543 (1947). At the end of the first sentence quoted, Kallmann cites GATES, HUMAN GENETICS (1946).

Abnormality is always the result of change. Change, however, will not differentiate *disease* from *health.* While it is characteristic of the onset of those modes of functioning classified as *disease,* change is also typical of the restoration of those modes of functioning referred to as *health.* Whether a particular mode of functioning, classified as *disease,* is more changeable than one referred to as *health* depends on the particular modes referred to in a specific situation.

It may be useful for some purposes to create a subcategory of *disease* called *defect. Defect* would refer to certain modes of functioning which, because of structural or other factors, have reached a more or less stationary level. This Article, however, will not discuss the special problems of this subcategory.

e. Other Observations

Some writers[47] favor including "alteration in total equilibrium" as an element of the concept of *disease.* The definition proposed here, however, omits that factor because the meaning of "equilibrium" as an empirical term has not in this context been sufficiently clarified.[48]

The proposed definition also omits explicit reference to the temporal dimension, or the characteristic of change. The use of the word *reaction* should sufficiently suggest both of these elements.

The definition refers to external and internal conditions in the conjunctive rather than disjunctive because *disease* and *health* involve organisms which are continually interacting with both parts of their environment.[49] Finally, the proposed definition omits any reference to etiology.[50]

C. The Value Component of Mental Disease and Mental Health

Many of those who have thought about the concepts of *disease* and *health* have had to struggle with questions of values. Personal preferences differ among men; social approval or disapproval of various types of functioning is not uniform throughout the world. Also, human characteristics which in one situation would be an asset may, in other situations, be a liability; no one is equally suited for every task that might be required of him or which he may want to undertake.

47 Seguin, *The Concept of Disease,* 8 PSYCHOSOMATIC MEDICINE 252, 256 (1946); DUNBAR, EMOTIONS AND BODILY CHANGES 746 (4th ed. 1954).

48 See also Lewis, *supra* note 23, at 113.

49 See, *e.g.,* PERKINS, CAUSE AND PREVENTION OF DISEASE 21 (1938); Seguin, *supra* note 47, at 256.

50 The exclusion of etiological connotations from the term *disease* has already been discussed. See pp. 397-98 *supra.*

1. Subdivisions of Functioning

It is very important to distinguish subdivisions of functioning [51] from behavior. Human functioning can be conceptualized into a number of subdivisions,[52] even though such arbitrary units do not exist in nature. Although the whole must be kept in mind,[53] these subdivisions have a pragmatic value. Behavior, on the other hand, is not a mental function, but the product and evidence of what is occurring as a result of bodily and mental functions.

Traditionally, *disease* has meant the disturbance of some subdivision of total human functioning, such as respiration, rather than total functioning or conduct.[54] Whatever the historical basis of this viewpoint, it ought to be retained. It is a useful means by which to differentiate problems of malfunctioning from the moral issue of what is good or evil. The basic disagreement within segments of society over moral issues is one of the motivating factors for attempting to redefine *mental disease* in the present Article.

Variations in standards of social behavior, religious precepts, and civil and criminal codes evidence the wide disagreement over conduct norms. However, all men share, have shared, and are likely to continue to share a common concern to avoid and deal effectively with those modes of sub-functioning which involve pain or danger of death. These two values can, therefore, be included in a definition of *mental disease* without provoking the controversy and confusion that other contested values would.

2. Pain and Danger of Death

The two values upon which the concepts of *disease* and *health* are herein based are the prolongation of life and the abolition of pain. Literally, *disease* means dis-ease. "The sphere of disease is the realm of pain, disability and death, for its major groupings, while the minor stages we can call (subject to quibbling) 'unpleasant' or 'disagreeable,' or some such term." [55] As another writer has said, "For most people, over long stretches of time, ill-health has meant feeling ill, suffering

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[51] Lewis, *supra* note 23, at 118. Lewis uses the term *part-function* or *function*.

[52] My meaning might perhaps be made more precise by use of the term *intrapersonal function*. See Grinker, *The Intrapersonal Organization*, in GRINKER, TOWARD A UNIFIED THEORY OF HUMAN BEHAVIOR 3 (1956). I might then refer to *mental functions* as *intrapsychic functions*. For an example of use of this latter term see GIBBENS, TRENDS IN JUVENILE DELINQUENCY 18 (World Health Organization Public Health Papers No. 5, 1961).

[53] See Lewis, *supra* note 23, at 112-13; see also King, *What Is Disease?*, 21 PHILOSOPHY OF SCIENCE 193 (1954).

[54] Lewis, *supra* note 23, at 117-18.

[55] King, *supra* note 53, at 195.

pain or incapacity, and going in danger of death or mutilation." [56] If neither pain nor danger of death is present in some stated degree, there is no functioning classifiable as *disease* under the proposed definition. Disability and incapacity, in turn, accompany those modes of functioning which contain these two elements.[57]

The two normative elements included within the concepts of *disease* and *health* are accepted both by physicians and the rest of society. It it true that these values cannot be derived or validated empirically; they were selected as a matter of preference. But by basing the concepts of *disease* and *health* upon them, it is possible to distinguish *disease* from the cultivation of functioning in accordance with other value goals. This does not mean, however, that the choice of these values was without any rational basis. They are unique in that they are universally felt, whereas any other goals would be matters of dispute. In addition, the choice ultimately is between the two values chosen and all others of a particular culture relating to the meaning of life.[58]

This does not mean, however, that men should always be satisfied with functioning which is merely free from pain and which prolongs life. Such functioning is not invariably the most desirable. In certain situations, wisdom or duty may require a sacrifice of health to some higher goal.[59] But by removing all other values from the concept of *disease,* legislators can recognize that the additional objectives are matters of personal or community preference, and deal with them accordingly. In this way, it is possible to evaluate intrapersonal functioning independently of judging conduct according to public or private conduct norms.[60]

Of course, pain and danger of death themselves present problems. Nevertheless, they can be used in an impressionistic way to distinguish

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[56] Lewis, *supra* note 23, at 117. See also Redlich, *The Concept of Normality,* 6 AM. J. PSYCHOTHERAPY 551, 553-54 (1952).

[57] According to the proposed definition, the term *mental disease* means that any of the mental functions involves either a stated degree of pain, or a stated degree of danger of death, or both. *Mental health,* on the other hand, means that each of the mental functions involves less than a stated degree of pain and less than a stated degree of danger of death.

[58] See CAROTHERS, THE AFRICAN MIND IN HEALTH AND DISEASE 71 (World Health Organization Monograph Series No. 17, 1953); DUBOS, MIRAGE OF HEALTH 218-19 (1959); Redlich, *The Concept of Normality,* 6 AM. J. PSYCHOTHERAPY 551, 563 (1952); Ruesch, *Communication and Mental Illness: A Psychiatric Approach,* in RUESCH & BATESON, COMMUNICATION 71-72 (1951), see text accompanying note 88 *infra*; Redlich, *supra* at 555; Wilder, 6 AM. J. PSYCHOTHERAPY 557 (1952).

[59] See COHEN, REASON AND NATURE 441-42 (2d ed. 1953).

[60] See Wootton, *Sickness or Sin?,* 159 TWENTIETH CENTURY 433, 440 (1956):

> Even in the honoured name of science, the lay community must not abdicate from the right and the duty of choosing its own values. Indeed, any attempt to do so would be to render ill service to science itself; for the success of scientific investigation has always depended, and always must depend, upon the complete exclusion of elements of value.

what others call psychoses and severe neuroses from other modes of functioning.[61]

3. A Sliding Dividing Line

The amount of pain and the degree of the probability of death which divide *health* from *disease* depend upon the purpose for which judgment is being made. Man constantly experiences some discomfort and is always in some danger of death. The amount of either that we are willing to tolerate will depend on what we are trying to accomplish.

Indefinite prolongation of life and abolition of pain have been postulated as the goal, but nothing will be gained by setting the dividing line between normality and abnormality, *health* and *disease,* immediately below the optimum. On the other hand, nothing will be lost if the line between *health* and *disease* is drawn sufficiently below the optimum to accommodate specific purposes. The result will be that in most instances a substantial proportion of the population will be regarded as normal and healthy.

4. Tasks and Environment Not Evaluated

Occasionally, functioning which entails considerable pain or danger of death may be described as the normal reaction of a "normal" individual to "abnormal" stimuli.[62] Apparently, what is meant is that most individuals who are classified as healthy in a "normal" environment would react as did the individual in question when placed in a second "abnormal" environment.

The multiple meanings of "normal" and "abnormal" cause confusion and lead to difficult value questions. Should a man live in a tropical climate where certain insects and microorganisms flourish, or in a northern climate where these things are uncommon? Should he expose himself or be exposed by others to military combat, flood, fire, or other catastrophes? Should a man lead an easy, unhurried life, or drive himself to the utmost? Logically these questions reduce themselves to the ultimate inquiry: What is the good or virtuous life and what is its setting?

To avoid possibly unanswerable ultimates and thereby provide a consistent meaning for *disease* and *health,* it is best to stipulate that

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[61] "[I]t seems justifiable to divide [mental] illness and [mental] health into two categories—the first roughly coinciding with psychosis and severe neurosis, the second including mild and transitory mental disturbances." Redlich, *The Concept of Health in Psychiatry,* in LEIGHTON, CLAUSEN & WILSON, EXPLORATIONS IN SOCIAL PSYCHIATRY 138, 158 (1957); see text accompanying note 87 *infra.*

[62] The problem is best illustrated in Tinklepaugh, *When Is Normal Normal?,* 69 SCIENCE 428 (1929).

these concepts only involve the abolition of pain and avoidance of death in whatever environment particular tasks or activities are undertaken by the individual being classified. This approach obviates any need to determine whether it is the environment, the task, or the individual that is abnormal.

5. Specifying the Relevant Facts

The concepts of *disease* and *health* are used as means by which to evaluate the intrapersonal functioning of individuals who are doing something, whether resting or performing, in interaction with their environment. The factual picture will vary depending upon the characteristics of the person involved—his age, sex, previous history—, the types of activities or tasks in which he is engaged, and the characteristics of his environment.[63] The individuals who are being studied may be referred to as the population. The environment within which they function is not only physical, but also human and nonhuman. It may contain plant and animal life of all sorts, as well as other humans with their own actions and expectations. In addition, the factual picture will vary according to where the line between *health* and *disease* is drawn. In order to be accurate, it is important to describe the total picture of population, environment, and dividing line with sufficient precision that it can be compared with similar settings, but not confused with those that are dissimilar.

6. Cultivation of Functioning

Under the proposed definition, treatment which does not seek solely to mitigate pain and prolong life cultivates functioning—that is, seeks to achieve additional goals. *Illness* and *disease* have been used as labels to increase public acceptance of what doctors consider to be the full potential of medical and psychiatric treatment to create well being. In order to mark out the neuroses and behavior problems as legitimate areas of psychiatric concern, it is simplest to refer to them as disease. To the extent that this designation is accepted by the rest of society, the sick role will apply. When someone is considered ill, pressure is put on him by his fellows to seek medical help. As a result, the anxious person, the alcoholic, and the parent of a child with a behavior problem, instead of relying on nonmedical alternatives for dealing with his difficulty, will feel compelled to seek the assistance of a physician.[64]

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[63] See, *e.g.*, Lewis, *Health as a Social Concept*, 4 BRIT. J. SOCIOLOGY 109 (1953); RYLE, CHANGING DISCIPLINES 77 (1948).

[64] See note 19 *supra*. Compare Szasz, *The Myth of Mental Illness*, 15 AM. PSYCHOLOGIST 113, 118 (1960):

> The notion of mental illness thus serves mainly to obscure the everyday fact that life for most people is a continuous struggle, not for biological

Even if the medical profession has little to offer a particular patient, it may, by an adjustment of labels, tell the public that a moralistic attitude towards his case is inappropriate.

Of course, cultivation of functioning, when defined as the pursuit of additional value goals, can be beneficial. There is no reason why a patient and doctor, who have voluntarily and mutually agreed on the goals which they will pursue, should not carry treatment beyond the reduction of a certain amount of fear or the elimination of a threat to life. By cosmetic surgery or by psychotherapy, the patient may perhaps be made a more attractive person. Within the bounds of legal and ethical rules, doctors and other social agencies may be able to aid those who seek their assistance to lead happier and more productive lives.[65] In fact, through such diverse mechanisms as education and imprisonment, the state may actually compel the cultivation of functioning although the subject is not in agreement with the goals.

But, since disputed values may be involved, they should be dealt with as such rather than obscured by the titles *disease* or *health.*[66] It is impossible and certainly undesirable to mask the nature of particular value preferences. There is no reason why it should be more difficult without the label *illness* than with it to convince the public that the "normal neurotic," the alcoholic, the repeated offender, and the homosexual have problems for which medical and psychiatric treatment are effective. The label, in fact, may repel as many patients as it attracts. In addition, it is not entirely clear that the sick role is always beneficial.

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survival, but for a "place in the sun," "peace of mind," or some other human value. For man aware of himself and of the world about him, once the needs for preserving the body (and perhaps the race) are more or less satisfied, the problem arises as to what he should do with himself. Sustained adherence to the myth of mental illness allows people to avoid facing this problem, believing that mental health, conceived as the absence of mental illness, automatically insures the making of right and safe choices in one's conduct of life. But the facts are all the other way. It is the making of good choices in life that others regard, retrospectively, as good mental health!

65 "Psychoanalysis has little resemblance to most forms of medical treatment; its methods are educational and its goals prescribe a new pattern of living and a reorientation in many basic values. Another aspect of such analytic treatment is its interminability. . . . The concept of health thus becomes an ideal which is never completely reached." Redlich, *The Concept of Health in Psychiatry*, in LEIGHTON, CLAUSEN & WILSON, EXPLORATIONS IN SOCIAL PSYCHIATRY 138, 158 (1957). See also Lewis, *supra* note 63, at 120.

66 Compare Wootton, *Sickness or Sin?*, 159 TWENTIETH CENTURY 433, 436-37 (1956):

> It follows that somewhere, somehow, there must be a recognizable distinction between those troublemakers and those troubles which are properly the doctor's business and those which (even though they may get wished upon him) are not. . . . Hence the dilemma: either our psychiatrist must be spending his time upon those who are not really ill at all (a waste, surely, of his special talents?) or our conception of mental illness must be much too narrow, and needs to be widened to include pretty well everyone who is in trouble of any kind.

It may, in certain circumstances, actually worsen a condition or give rise to further complications.[67]

D. Mental Health and Its Relation to Mental Disease

It is quite common for doctors and laymen to think of *disease* and *health* as dichotomous terms. *Health* is often defined as the absence of *disease.*[68] This approach, however, wrongly suggests that *disease* is a thing that can either be present or absent.[69] In addition, it describes *health* only in negative terms. The definition here proposed is not completely free of this dichotomous view, but it does attempt to explain *disease* and *health* as two parts of a single continuum across which a dividing line has at some point been drawn.[70] *Health* is related to mental functions evaluated in terms of pain and danger of death in the same way as is *disease.* The proposed definition makes clear that the line between the two may vary. Finally, it makes it possible and meaningful to speak of degrees or levels of *health.*[71]

Throughout history it has also been common to think of *health* in a far more ambitious way. Etymologically, to heal means to make whole. The Constitution of the World Health Organization defines *health* as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." [72] But again the definition has gone beyond the problem of *health* and *disease* and has entered the realm of cultivation of functioning. The better approach is to "keep social well-being conceptually distinct from health so that their interrelations can be better observed and analysed." [73]

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67 "[W]e may wonder to what extent the process of self-perception as mentally ill makes the patient sicker and to what extent this is a necessary phase in recovery?" Gruenberg & Bellin, *The Impact of Mental Disease on Society*, in LEIGHTON, CLAUSEN & WILSON, EXPLORATIONS IN SOCIAL PSYCHIATRY 341, 349 (1957).

68 See, *e.g.*, Redlich, *The Concept of Health in Psychiatry*, in LEIGHTON, CLAUSEN & WILSON, EXPLORATIONS IN SOCIAL PSYCHIATRY 138, 140, 143 (1957).

69 "The infestation or 'devil-possession' theory, this ontological conception of mental disease as a *thing* present or not present in the individual, is an erroneous, medieval and pre-medieval concept which persists in the minds of many laymen, not a few lawyers, and even a few physicians in spite of all sorts of effort to eliminate it." Karl Menninger, *Community Attitudes Vis-a-Vis the Offender*, in ABA SECTION OF CRIMINAL LAW, PROCEEDINGS 83, 85 (1958). See also RIESE, THE CONCEPTION OF DISEASE 78-81 (1953); Seguin, *The Concept of Disease*, 8 PSYCHOSOMATIC MEDICINE 252-53 (1946).

70 See Lewis, *supra* note 63, at 111.

71 See generally MEASUREMENT OF LEVELS OF HEALTH (World Health Organization Tech. Rep. Series No. 137, 1957).

72 WORLD HEALTH ORGANIZATION BASIC DOCUMENTS 1 (12th ed. 1961).

73 Lewis, *supra* note 63, at 110. See also Firth, *Acculturation in Relation to Concepts of Health and Disease*, in GALDSTON, MEDICINE AND ANTHROPOLOGY 129, 142-43 (N.Y. Academy of Medicine Lectures to the Laity No. 21, 1959).

II. The Implications for Law of Mental Health and Mental Disease as Redefined

A. The Importance of Classification as Disease: Robinson v. California

The characterization of narcotic addiction as an illness in *Robinson v. California* [74] leaves no doubt about the importance of the concept of *disease* for courts and legislatures whenever compulsory measures, particularly penal sanctions, are being considered. Yet the *Robinson* opinion contains no careful analysis of that concept. The majority speaks of narcotic addiction as an illness, which indeed may be the better view, but it fails to cite any medical authority for that proposition. Nor is the system of classification seized upon subjected to any reasoned analysis. Instead, the majority of the Court brushes aside any doubts by referring to a concession made in the state's brief and a statement made by the Court itself thirty-seven years earlier, that persons addicted to narcotics "are diseased and proper subjects for [medical] treatment." [75] Only in the concurring opinion of Mr. Justice Douglas is there any mention of the uncertainty beclouding the characterization accepted by the majority. "Some say the addict has a disease. . . . Others say addiction is not a disease but 'a symptom of a mental or psychiatric disorder.' " [76]

The new importance of the concept of *disease* to the law is further illustrated by the fact that the Court could have reached the same result

[74] 370 U.S. 660 (1962), *rehearing denied, petition for abatement of judgment as moot denied,* 31 U.S.L. Week 3165 (U.S. Nov. 13, 1962), 111 U. Pa. L. Rev. 122.

[75] 370 U.S. at 667 n.8, citing Linder v. United States, 268 U.S. 5, 18 (1925). In that case the conviction of a physician for violation of the Harrison Narcotic Law was reversed by the Court on the ground that it had not been alleged or shown that the defendant's conduct (in giving a known addict four tablets containing morphine for the sole purpose of relieving conditions incident to addiction and keeping the addict comfortable) involved acts which were other than acts coming within the category of medical practice in good faith according to medical standards. The problem of classification upon which the result on appeal turned related not to the classificatory category of *disease* but rather of *medical practice.* On this point, Mr. Justice McReynolds said, "What constitutes *bona fide* medical practice must be determined upon consideration of evidence and attending circumstances." 268 U.S. at 18. The Court in *Linder* used the treatment criterion of *disease* as a step toward the result, which was based on the conclusion that conduct outside the limits of medical practice had not been shown. The concept of medical practice was relevant because the Court construed the Harrison Law as not involving the intent on the part of Congress to regulate medical practice in the states.

[76] 370 U.S. at 671-72 (Douglas, J., concurring). See *Treatment of Drug Addicts: A Survey of Existing Legislation,* 13 Int'l Digest of Health Legislation 3, 4 (1962):

> In certain countries . . . drug addiction is considered to be an offence involving severe penalties, whilst in others it is regarded by the population as being little more than a "normal" habit. It would seem, however, that in many countries, the current attitude towards the problem is undergoing a change. Indeed, it is becoming more and more recognized that the drug addict is a sick person who, above all else, is in need of suitable treatment.

without employing the reasoning it used.[77] The crime of which the defendant was convicted did not require proof of any act or omission. But actus reus would seem to be a necessary element of any crime.[78] The moral idea that it is wrong and uncivilized to punish the sick merely for being sick, however, had such a powerful hold upon the minds of the majority, that they chose not to rely on this more traditional approach.

B. Legislative Policy Implications of Classification as Disease: The Wolfenden Report

The Wolfenden Committee's Report[79] on homosexuality is an excellent example of a careful attempt to limit the scope of the concept of *disease* as it is socially or medically defined. The Report considered what legal consequences ought to follow, with respect to definition of offenses and the treatment of offenders, if homosexuality is regarded as a disease. The Committee had been directed to consider "the law and practice relating to homosexual offences and the treatment of persons convicted of such offences by the courts" and to "report what changes, if any, are . . . desirable."[80] Its Report treated the question of whether homosexuality is a *disease* as academic rather than practical.[81]

> Even if it could be established that homosexuality were a disease, it is clear that many individuals, however their state is reached, present social rather than medical problems and must be dealt with by social, including penological, methods. This is especially relevant when the claim that homosexuality is an illness is taken to imply that its treatment should be a medical responsibility. Much more important than the academic question whether homosexuality is a disease is the practical question whether a doctor should carry out any part or all of the treatment.[82]

The Committee did conclude that homosexual behavior between consenting adults in private should no longer be made criminal. How-

[77] "We hold that a state law which imprisons a person thus afflicted as a criminal, *even though he has never touched any narcotic drug within the State or been guilty of any irregular behavior there,* inflicts a cruel and unusual punishment in violation of the Fourteenth Amendment." 370 U.S. at 667. (Emphasis added.)

[78] See KENNY, OUTLINES OF CRIMINAL LAW 14 (17th ed. Turner 1958); PERKINS, CRIMINAL LAW 470 (1957); WILLIAMS, CRIMINAL LAW—THE GENERAL PART, at 1, 10-11 (2d ed. 1961). See also Lacey, *Vagrancy and Other Crimes of Personal Condition,* 66 HARV. L. REV. 1203 (1953).

[79] Committee on Homosexual Offences and Prostitution, *Report,* CMD. No. 247 (1957). The Committee is often referred to by the name of its chairman, Sir John Wolfenden.

[80] *Id.* ¶ 1, at 1.

[81] *Id.* ¶¶ 31, 191, at 15, 66.

[82] *Id.* ¶ 31, at 15.

ever, it assumed that certain other homosexual conduct would remain punishable, such as between an adult and a child, or in cases not involving consent. The Committee went on to discuss a wide range of correctional measures that would be possible within the existing structure of the law, and also recommended improved psychiatric care in prisons. None of these conclusions or recommendations, however, was based on any finding that homosexuality is a disease. In fact, the Committee's opinion was quite to the contrary.

> [T]he evidence placed before us has not established to our satisfaction the proposition that homosexuality is a disease. This does not mean, however, that it is not susceptible to treatment. As we explain elsewhere, psychiatrists deal regularly with problems of personality which are not regarded as diseases. It seems to us that the academic question whether homosexuality is a disease is of much less importance than the practical question of the extent to which, and the ways in which, treatment can help those in whom the condition exists.[83]

The Committee also touched upon the relationship of the concept of *disease* to capacity to control behavior, and to responsibility. "The claim that homosexuality is an illness carries the further implication that the sufferer cannot help it and therefore carries a diminished responsibility for his actions. Even if it were accepted that homosexuality could properly be described as a 'disease,' we should not accept this corollary." [84]

C. The Impact of the Proposed Definition

In actual application to law, the proposed definition of *mental disease* and *mental health* could be used to make the division—made by

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[83] *Id.* ¶ 191, at 66.

[84] *Id.* ¶¶ 32-33, at 15-16. The Committee continued as follows:

> There are no *prima facie* grounds for supposing that because a particular person's sexual propensity happens to lie in the direction of persons of his or her own sex it is any less controllable than that of those whose propensity is for persons of the opposite sex. We are informed that patients in mental hospitals, with few exceptions, show clearly by their behavior that they can and do exercise a high degree of responsibility and self-control; for example, only a small minority need to be kept in locked wards. The existence of varying degrees of self-control is a matter of daily experience—the extent to which coughing can be controlled is an example—and the capacity for self-control can vary with the personality structure or with temporary physical or emotional conditions . . . .
>
> Some psychiatrists have made the point that homosexual behavior in some cases may be "compulsive," that is, irresistible, but there seems to be no good reason to suppose that at least in the majority of cases homosexual acts are any more or less resistible than heterosexual acts, and other evidence would be required to sustain such a view in any individual case.

Ibid. Compare Scott, *Psychiatric Aspects of the Wolfenden Report*, 9 BRIT. J. DELINQ. 20, 28 (1958).

others on the basis of a somewhat different analysis—between psychoses and severe neuroses, on the one hand, and other ways of functioning, on the other.[85]

> [W]e know what the seriously ill person in a given culture is. That we do know. In this respect we agree, incidentally, with policemen, with the clerk in the drug store. Our crude diagnostic criteria are reasonably similar.
>
> What the normal and the normal neurotic is we don't know. However, . . . the difference is not between the various shades of gray in the neurotic scale where we can draw a line, but the difference is between the severely ill on one side, and between the normal and the neurotic on the other side. . . .
>
> [W]e could, by operational criteria, say this: there is one group, the severely abnormal, which is characterized by a definite urgency to enter treatment. They have to go to a psychiatrist. If they don't go to a psychiatrist, a situation arises which is as serious as in any other medical emergency. If we have too many schizophrenic people around the population, there is danger, and society responds to this by legalizing removal of the seriously ill. For the neurotic population no such urgency exists. The relationship between a neurotic patient and his therapist is very much a voluntary one. Nobody can force the patient to seek treatment.[86]

The proposed definition would include the psychoses and severe neuroses as *disease,* by saying that in psychotic conditions, where the sense of reality is crudely impaired,[87] there is increased danger of death, and often substantial pain or distress. In severe neurosis, there is pain from acute anxiety, and in some cases there may also be inability to deal with some of the ordinary hazards of modern civilization that threaten life and limb. Pain and danger of death, however, are not involved to the same degree in other modes of mental functioning.

When specifically related to questions of commitability and irresponsibility, one of the effects of the proposed definition on law would be to provide a more explicit, rational basis for defining the category of persons who may be subjected to involuntary hospitalization or

[85] I think of the line between *mental health* and *mental disease* as adjustable. Therefore, it should be borne in mind that the category of *mental disease* might also be made narrower or wider than suggested above.

[86] Redlich, in MILBANK MEMORIAL FUND, INTERRELATIONS BETWEEN THE SOCIAL ENVIRONMENT AND PSYCHIATRIC DISORDERS 120-21 (1953). See also Redlich, *The Concept of Normality,* 6 AM. J. PSYCHOTHERAPY 551, 564 (1952): "Repeatedly in this paper the statement has been made that the severely disturbed group—the extremely abnormal which is not identical with psychotic reactions but includes the severely neurotic reactions—can usually be clearly recognized."

[87] See Waelder, *Psychiatry and the Problem of Criminal Responsibility,* 101 U. PA. L. REV. 378, 384 (1952), quoted in text accompanying note 24 *supra.*

treatment as criminally irresponsible. Currently, in the application of tests of commitability and irresponsibility, *mental disease* is said to mean psychosis. But by using the definition suggested, a somewhat larger group would be included as potentially commitable or irresponsible. Not included, in the absence of explicit legislative provisions, however, would be those classified as having conduct disorders—habitual offenders and other sociopaths—exhibitionists, homosexuals, prostitutes, and those engaging in compulsive stealing.

It is also important to consider the effect of the proposed definition on legislative pursuit of other goals of functioning by use of compulsory measures. The stringent approach advocated here concerning the values to be included in the concepts of *mental disease* and *mental health* may appear more persuasive when the alternatives are considered. The basic question is which of the many goals clamoring to be included in the concept of *disease* would not become stifling, even tyrannical, if it were the pivot upon which commitment to a mental hospital, for example, was made to turn. Consider the legal implications of a statement—not addressed in the original to any legal context—which defines *health* according to the "physical and mental processes which seem to be desirable to the system in power."

> The nature of pathology implies the existence of a concept of health, and all medical and psychiatric thinking is geared toward helping the patient achieve health. *Mental health is obviously defined in terms of the culture in which the patient and the therapist live.* The concept of health can be viewed as a structural assumption describing a series of conditions pertinent to processes which prolong the optimal functioning of an individual. The concept of disease, in contrast, denotes deviation from optimal functioning through the introduction of a number of reversible or irreversible processes. *Inasmuch as health is defined in each culture in terms of those physical and mental processes which seem to be desirable to the system in power, the American concept of health can be derived from that which will be said about the American culture as a whole.* To be able to compete and to successfully grasp the opportunity which equality provides for the individual defines the essential meaning of living in America. In order to do these things, an American citizen must be strong, self-reliant, independent, free of physical disease, able to get along in a group, ready to adapt to emergencies, capable of caring for children and the family, and not a public liability. The healthy individual is expected to use his power for his own benefit with restraint and wisdom.[88]

[88] Ruesch, *Communication and Mental Illness: A Psychiatric Approach*, in RUESCH & BATESON, COMMUNICATION 71-72 (1951). (Emphasis added.)

Clearly, the applicability or nonapplicability of compulsory measures ought not to depend on such criteria as ability "to get along in a group," not being "a public liability," or use of power for one's own benefit "with restraint and wisdom," no matter how enthusiastic some members of society may be about those goals in relation to voluntary cultivation of functioning.

It is not necessary to conclude, however, that the legislature cannot use compulsory measures to cultivate other modes of functioning not based on the values of avoiding pain or danger of death. The argument of this Article is not to that effect.

The argument made here is that if the legislature wishes to pursue values other than the universally accepted ones of avoiding pain and death—by civil commitment procedures, criminal responsibility rules, or correctional arrangements—it should face those value problems explicitly by enacting specific provisions for each category of cases. If additional classes of persons other than those suffering from *mental disease*, as here redefined, are to be subjected to restraint and compulsory treatment, the legislature, which in its representative capacity speaks for society, should face up to those problems explicitly, and specifically and unambiguously state what is to be done.

The values dealt with in such explicit provisions, might conceivably have to do with: (a) mature sexual goals as opposed to those concerned with sexual relations with members of the same sex, with children, or for hire; (b) mature goals in the management of tensions as opposed to release of tensions through excessive use of alcohol[89] or barbituates, or use of narcotics;[90] (c) the goal of reality-oriented acquisition of property as opposed to senseless compulsive stealing under circumstances where detection and apprehension are highly likely, or where a motive for gain is lacking; (d) the goal of living a constructive life as opposed to a life characterized by x number of convictions of felony, or y number of convictions of any offense, or z number of convictions of a particular kind of offense within a specified period of time. Persons in any of these categories might be made commitable, declared irresponsible, or, on conviction of a related offense, sentenced to a greater or shorter term or to a special treatment facility. Needless to say, these possibilities are mentioned here only for purposes of illustration, without taking any position on their desirability.

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89 See LINDMAN & MCINTYRE, THE MENTALLY DISABLED AND THE LAW 82-91 (1961) (Table II-J, Statutory Definitions of Alcoholics and Drug Addicts; Table II-K, Hospitalization of the Mentally Deficient, Epileptics, Alcoholics, and Drug Addicts).

90 *Ibid.* See also *Treatment of Drug Addicts: A Survey of Existing Legislation*, 13 INT'L DIGEST OF HEALTH LEGISLATION 4 (1962).

D. *Recapitulation: Some Legally Important Characteristics of Mental Disease*

What are the characteristics and logical implications of *mental disease* and *mental health,* as here redefined, which are most likely to be important for the structuring and application of compulsory legal measures?

(1) The concepts of *mental disease* and *mental health* are susceptible of explicit definition supported by reasoned analysis.

(2) The concepts of *mental disease* and *mental health* can be used as devices for legal classification. Even as implicitly defined in present usage, these concepts are used for purposes of civil commitment and in tests of criminal responsibility.

(3) The classificatory system of *mental disease* and *mental health* includes value preferences.

(4) The values included within the classificatory system of *mental disease* and *mental health* relate to the goals of avoiding death and abolishing pain. They do not include other attributes and goals which from time to time may be considered valuable. A psychological or physiological condition, for example, involving sexual preference for members of one's own sex would not, as such, be classifiable within the category of *mental disease.*[91]

(5) Norms relating to conduct fall outside of the concepts of *mental disease* and *mental health.* Habitual stealing, for example, would not, as such, be regarded as coming within the category of *mental disease* or ill health. The norms of the conceptual system of *mental disease* and *mental health* evaluate intrapsychic functioning.

(6) The concepts of *mental disease* and *mental health* do not include hypotheses as to etiology. The question of whether a particular mode of functioning is due to psychic, somatic, or unknown causes is not relevant to the question of whether that mode of functioning comes within the category of *mental disease.*

(7) The body of social beliefs and expectations concerning *mental disease,* including the sick role,[92] do not form part of that concept. That is not to say, however, that these social views should not be taken into account in formulating legal policy. That is another matter to be dealt with in terms of specific legal problems.

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91 Compare discussion of the subject by the Wolfenden Committee, pp. 411-12 *supra.*

92 See notes 19, 84 *supra.*

(8) The concepts of *mental disease* and *mental health* have been here defined without reference to treatment.[93] The question of what cases should be treated is a separate problem of considerable complexity.[94] The position taken here, however, is that the area of treatment and scope of prudent use of specialized medical and auxiliary resources extend beyond the classificatory system of *health* and *disease*. Within the limits set by law and professional ethics, they include the pursuit of other goals deemed valuable by the individual or society.

III. The Legal Decision Maker, the Legislator, and the Meaning of Mental Disease

If legislators and judges are to deal properly with civil commitment, criminal responsibility, and the definition of crime, they must have a sound understanding of what is meant by *mental disease*.

The judge, juror, hospital superintendent, or certifying physician, in dealing with questions of responsibility and commitability, must do at least two things. First, he must formulate some notion of what he means by *mental disease*. Second, he must decide whether the condition of the individual comes within that meaning. In other words, he must formulate some idea—whether precise and explicit or vague and implicit—of the characteristics of *mental disease*, and he must then decide whether the condition of the individual falls inside or outside of that class.

A. Can the Meaning of Mental Disease Be Found as an Objective Fact?[95]

Can the legal decision maker look for the meaning of *mental disease* in nature, to be discovered by scientists? In the past, this may

[93] "Does treatableness have any bearing on whether a condition is classified as a mental disease? If so, is it true that there are some types of psychoses . . . which are recognized by all to be mental diseases but which are not treatable?" United States v. Amburgey, 189 F. Supp. 687, 695 (D.D.C. 1960) (Youngdahl, J.). (Footnote omitted.) See also Campbell v. United States, 307 F.2d 597, 609, 611 (D.C. Cir. 1962) (dissenting opinion).

[94] See, *e.g.*, discussion in Wolfenden Report, pp. 411-12 *supra*.

[95] The intended meaning of the term *objective fact* is that stated by Hempel in the following passage: "Science aims at knowledge that is *objective* in the sense of being inter-subjectively certifiable, independently of individual opinion or preference, on the basis of data obtainable by suitable experiments or observations." Hempel, *Introduction to Problems of Taxonomy*, in Field Studies in the Mental Disorders 3, 7-8 (Zubin ed. 1961).

The general question of whether mental disease is a fact may arise apart from the legal setting. A tripartite answer may be given:

a. Questions concerning what is existing usage are factual questions.

b. "Proper" definition of mental disease is not a fact.

c. Where a stated definition is taken as "stipulated" or "given" for purposes of asking and answering the question, then the question "Is this a case of mental disease?" is a factual question.

See Reid, *Logical Analysis*, 114 Am. J. Psychiatry 397, 400 (1957): "[D]efinitions constitute necessary, but not sufficient, conditions of answering empirical questions."

have been the prevailing view in law [96] and in medicine; traces of this approach can still be found in both of these fields and in the contemporary thinking of laymen.[97] This view, however, is inconsistent with present knowledge of the world.[98] Since there are alternatives which are consistent, it can be discarded.

B. *Is the Decision Maker Directed To Find the Meaning of Mental Disease in Contemporary Medical Usage?*

Another question is whether statutes which use the term *mental disease* impliedly direct the legal decision maker to find the meaning of that term in contemporary medical usage within the state, the United States, or throughout the world. One difficulty is that medical usage is conflicting and changing; there may be no satisfactory way of determining what the prevailing meaning is.

Even if there were uniformity among psychiatrists, however, a basic objection would remain. Value choices, which resolve themselves into questions of social philosophy, are involved in the meaning of *mental disease.* When value choices are at stake, the view of a single professional group cannot be accepted unquestioned. Unless the prevailing usage of the term *mental disease* in medicine conforms to a social philosophy which legislatures and courts find sound in relation to the applicability of compulsory legal measures, it would be impolitic and unjust to adopt that usage.

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[96] See, *e.g.*, Letter From Judge Charles Doe of the New Hampshire Supreme Court to Dr. John E. Tyler, Professor of Mental Diseases, Harvard Medical School, Sept. 5, 1866, in Reik, *The Doe-Ray Correspondence: A Pioneer Collaboration in the Jurisprudence of Mental Disease*, 63 YALE L.J. 183, 187 (1953): "What is a diseased condition of mind is to be settled by science and not by law,—*disease is wholly within the realm of natural law or the law of nature.* The municipal, civil law established by men for human government does not declare what is disease of the mind any more than it declares what is disease of the lungs or the liver." (Emphasis added.)

[97] See note 69 *supra.*

[98] MAY, THE ECOLOGY OF HUMAN DISEASE 29 (1958): "A definition is but a tool; there is no absolute definition of anything." Reid, *Logical Analysis*, 114 AM. J. PSYCHIATRY 397, 398 (1957):

> [I]t seems obvious that classes, in any pragmatically relevant sense of the word, are not ontological realities existing in nature independently of our purposes and selections. It is not Nature . . . who sternly fixes limits to our classes. . . . Nature, in the romantic tradition as in sober fact, is indifferent, protean, and inexhaustible. It is *our* need to conquer that leads us to divide and to *select* out of the infinite possibilities . . . those properties that we feel best serve our purposes. . . .

Consider also Stengel's observation about even contemporary medical thinking that "the quest for disease entities has created the idea that our diagnostic concepts stand for biological realities with which it would be wrong to tamper." Stengel, *Classification of Mental Disorders*, 21 BULL. WORLD HEALTH ORGANIZATION 601, 612 (1959).

C. Does the Term Mental Disease Have Any Independent Meaning of Its Own?[99]

One other possible meaning of *mental disease* may be what the judge, juror, or medical expert thinks best in a particular case. Such an extraordinary proposition could seriously be put forward only in relation to the role of medical experts. Presumably, such a suggestion would imply that such medical determinations would not really be unguided, but would be influenced by professional norms.[100] But, except as guided by present law, there is no existing body of professional norms concerning the applicability and nonapplicability of compulsory measures. The basic difficulty is again one of value preferences.

D. The Meaning of Mental Disease Should Be Based on Reasoned Analysis

Any definition of *mental disease* and *mental health,* to be acceptable for use in connection with legal compulsion, cannot depend upon a supposed meaning to be found in nature, nor—since value questions are involved—can it be based on some hypothetical vote among psychiatrists, or an unguided delegation of discretion to the decision maker. Ultimately, it must be founded upon a reasoned analysis.

The definition proposed here is an attempt at such analysis. It is based upon a core of traditional usage. The value preferences involved are explicit; they relate to intrapsychic functioning and not to conduct. They have long been matters of common agreement and are likely to remain so. It is hoped that the proposed definition is also clear and definite.

E. Content of the Statutory Definition

Where classification as *mental disease* is explicitly made relevant in a statute, what should the legislature say, if anything, about the meaning it there intends for that term? Some of the conceptual groundwork for answering this question has been provided in this

[99] See, *e.g.*, ROCHE, THE CRIMINAL MIND 29 (1958): "[C]riminals differ from mentally ill people only in the manner we choose to deal with them."

[100] Speaking about criminal justice, Remington puts a question whose current legal import goes far beyond that particular subject matter:

> What are the relative roles of legal and professional norms of decision? As expertness increases there is a corresponding desire on the part of the experts to minimize the role of legal norms as methods of controlling important decisions. The relationship between legal norms and professional norms as means of insuring the responsible exercise of official power is therefore, of basic concern.

Remington, *Criminal Justice Research*, 51 J. CRIM. L., C. & P.S. 7, 16 (1960).

Article. Depending on the legislative purpose, a provision might exclude conduct norms from the classification[101] or explicitly refer to subdivisions of functioning.[102] However, in view of the great broadening of psychiatric activities and concepts, it may well be no longer legislatively sound to follow the usual past practice of saying nothing explicit about the meaning of *mental disease* in legal contexts.[103]

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[101] See MODEL PENAL CODE § 4.01(2) (Proposed Official Draft 1962), a provision addressed to repeated violation of criminal law or other conduct norms quoted in text accompanying note 8 *supra.*

A provision excluding from the statutory classification of *mental disorder* those conduct norms relating to promiscuity or other immorality is included in Mental Health Act, 1959, 7 & 8 Eliz. 2, c. 72:

> § 4. Definition and classification of mental disorder. . . .
>
> (5) Nothing in this section shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder, or from any form of mental disorder described in this section, by reason only of promiscuity or other immoral conduct.

[102] See COLO. REV. STAT. ANN. § 71-1-1(1) (1953), as amended, Colo. Sess. Laws 1957, ch. 162, § 1.1.1(1), which speaks of "mental or emotional functions."

[103] For the recommendation that the word "psychopath," as used in proposed legislation involving compulsory measures, should not be further defined, see Royal Comm'n on the Law Relating to Mental Illness and Mental Deficiency, *Report,* CMD. No. 169, ¶ 357, at 127 (1957). This recommendation was criticized in Morris, *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency,* 21 MODERN L. REV. 63, 66-67 (1958).

The Mental Health Act, 1959, 7 & 8 Eliz. 2, c. 72, which came after the Royal Commission's report, rejected the Commission's definitional point, and contained the following provision:

> § 4. Definition and classification of mental disorder . . . .
>
> (4) In this Act "psychopathic disorder" means a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment.

See also § 4(5), quoted in note 101 *supra.*