Reflections on the Nature of Mental Disorder

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Abstract

There is debate over what the proper scope of psychiatry is and what the nature of the conditions it treats are. The Psychiatrist Maurice Drury has described a number of cases of patients of his who came to him with what appeared to be psychiatric conditions that could also be understood in spiritual or religious terms. Is there a principle of differentiation between madness and religion?

I look at Thomas Szasz who has argued that Psychiatry, in applying the medical model, which is said to be free of any particular values, inevitably misunderstands the nature of the kind of problems people have that come to them as such problems are inherently ethical and defined against social values. Mental illness, as such, is a myth. Christopher Boorse and Jerome Wakefield have both produced theories that propose to offer a definition of mental disorder that is independent of any particular social order, that is, is objective and value free, construing mental disorder as biological or scientific fact. Such a theory is said to delineate the proper scope of psychiatric practice.

Such definitions however rely on a distinction being drawn between human nature and culture. The human subject is a union of the two meaning that such a distinction is not viable. In addition, the motivation for such a strict definition, making a definite distinction between the mentally unwell and the rest of the population has become less pressing given developments in our understanding both of ourselves and of the nature of mental disorder that have broken down and blurred the lines between normality and abnormality.

I argue that mental disorder should not be understood as representing a complete break from the world of truth and goodness. A shift that in a sense makes redundant the attempts to offer a definitive definition of the boundary between madness and sanity. In so far as there is a question over what the proper domain of psychiatry is, it is not to be found by discovering the true nature of mental disorder for the

concept itself covers a myriad of different kinds of human trials and tribulations. I explore Wittgenstein's notion of form of life and his reflections on language to argue that attempts at a final definition of mental disorder is not necessarily going to offer a satisfactory answer to questions such as Drury's. The application of the concept of 'mental disorder' is something that is related to a whole slew of clinical judgements to do with social and ethical norms, harm to the individual, contextual factors, the potential benefits of treatment and so on, all reflecting judgements that reflect our own manner of life. Psychiatry offers one particular avenue of understanding and healing amongst others.

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1 Introduction: Drury on Madness and Religion

"Health is organic innocence. It must be lost, like all innocence, so that knowledge may be possible".
-George Canguilhem, *The Normal and the Pathological*

1.1 Investigating the nature of mental disorder

The following is an investigation into the nature of mental disorder, that particular way of thinking about people's problems that makes up the body of knowledge that underlies the practice of psychiatry and mental health care in general. Why is such an investigation of interest and what kind of questions are involved? As a medical discipline psychiatry has been surrounded by levels of controversy not seen in other areas of medicine, for example, areas involved in such things as fixing broken bones, removing cancerous lesions, eradicating life threatening infectious diseases and so on. This is not to say that these areas of medicine do not have their own controversies. Debates over the effectiveness of a particular treatment and over matters of justice and the equitable distribution of limited health resources are both, for example, potential sources of controversy. Psychiatry, on the other hand, is controversial not only with regards what constitutes the most effective treatment, but indeed, whether there are such things as diseases of the mind for psychiatry to treat in the first place. If there are such things as diseases of the mind or psyche, how best are we to conceptualise or think of them? Are they essentially similar in nature to the kind of things that the rest of medicine deals with, or are mental disorders a fundamentally different kind of problem? This essay will attempt to shed some light on such questions.

Psychiatry deals with the human psyche and hence appears to touch closely on questions relating to the Good, ethically, politically and socially. How close, of course, is one of the major points of contention within the philosophy of psychiatry: the degree to which values and notions of the Good (ideology) play a role in defining what is to count as mentally unwell and in need of medical attention and what is to be seen as normal healthy human life. There are two levels to this contention. The first is over the question of whether values and a notion of the Good play any role at all in psychiatry. The second level regards, if we accept the presence of values at the first level, to what extent do these values play a role in psychiatry, and what ought we to make of this? If 'value judgements' do play a defining role, does it, for example, follow that Psychiatry should be abandoned as a field of medicine, that is, as a scientific/rational enterprise?

The nature of mental disorder is a complex issue. Two general poles of understanding can be hewn apart along the following lines. Is mental disorder best thought of, for example, as something that exists independently of the social and cultural contingencies of any particular society, that is, is Schizophrenia, or for that matter, something like Conduct Disorder, something that exists not only in modern, western, industrial cultures, but also, for example, amongst the nomadic communities who live upon the Mongolian-Manchurian steppe, or indeed, amongst hunter gatherer societies that existed before the agricultural revolution some 10000 years ago? An affirmative answer to this characterises 'naturalist' thinking on the topic. Or, is mental disorder relative to the social and cultural context in which the practice of psychiatry has developed? That is, are the two examples I have mentioned here only considered illnesses, and in need of medical treatment, because of what *society* deems to be healthy ways of living in terms of thoughts and actions? Perhaps, given a different set of values, these two examples may fall within the accepted spectrum of human life. This way of thinking about mental disorder understands it as being a social category, something that is defined against the cultural milieu. If this is so, is not the mental

health profession promoting a particular ideology, a particular set values? An accusation of psychiatry that often follows from this is that it is simply a form of promoting the ideology of the dominant culture of the day, making it as a practice contrary to the ideals of liberty, fraternity, and equality.

Put another way, either mental disorders are universal 'natural kinds' that are present in all societies, or they are relative to a particular manner of life. It is important here to notice that the values in-values out distinction drawn above does not fully parallel this distinction, although they are often drawn together. If psychiatric diagnoses are universal, found in all cultures and historical periods, it does not necessarily follow that the categories of psychiatry are therefore value free. It can be argued that psychiatric diagnoses are universal *and* that they are intimately intertwined with judgements of value and what counts as good human life. This can be argued, for example, by appealing to a universal notion of the Good. Iris Murdoch, for example, argues for the objectivity of the Good in a work titled *The Sovereignty of Good* (Murdoch, 1970). This is contrary to a line of thought that suggests Psychiatry is relative to particular cultures or manners of living and that this is precisely because psychiatric diagnoses involve values. The implicit assumption with this line of thought is that values are inherently subjective and relative, and that therefore a practice that is imbued with value judgements is too relative to a manner of life. This is an assumption that can be questioned. Of course, taking an objective approach to an understanding of the Good would not therefore do away with the need for sensitivity and understanding when it comes to different cultures.

The natural Vs cultural and the values in Vs values out debate define two key nodes in the debate I will be looking at. The position I will take in this essay is that values and a notion of the Good run deeply through Psychiatry and the mental health profession in general. As a corollary to this, I claim that it does not follow that simply because of this psychiatry loses its credibility as a rational enterprise that can

relieve suffering and help individuals live lives that are good. This is one of the positions I intend to move towards in this essay. I facilitate this move by arguing for a parallel shift in our understanding of what mental disorder is. A shift, very roughly speaking, from seeing mental disorder as necessarily a complete break from any form of meaningful order, to mental disorder being part, albeit perhaps at the edges, of the world of meaning (reason, truth and goodness).

It is worth setting out some terminology. I will use the term 'mental disorder' as a general term to refer to all the conditions that are set out in diagnostic manuals such as the Diagnostic and Statistical Manual of Mental Disorders (DSM). I use this to refer to the proper domain of psychiatry and mental health care in general. Various people writing on the subject use slightly different terms. Essentially, what I cover by this term is all of the psychological problems which the mental health profession understand as being within its purview. Other terms that cover roughly the same ground include mental illness, psychopathology, madness, insanity, lunacy, and mental health problems. The four principal thinkers I look at in this essay, Szasz, Boorse, Wakefield and Bolton, do not together use exactly the same terminology, and some give specialist definitions to some terms for their own purposes.

Thomas Szasz uses the term ‘mental illness’ which parallels my use of the term ‘mental disorder’. Derek Bolton uses ‘mental disorder’ to cover the same ground. Jerome Wakefield too uses the term ‘mental disorder’. However he introduces the notion of 'dysfunction' which for Wakefield is a value free natural fact that underlies the existence of mental disorders- something that can be identified as a disease both in the 21st century urban individual as well as the nomad upon the Mongolian-Manchurian steppe. A mental disorder is a dysfunction that causes harm to the individual. Christopher Boorse uses the terms ‘disease’ and ‘illness’, structuring the conceptual landscape in a way similar to Wakefield. Disease is what exists independently of our social judgements of what counts as good health and so on. Illness on

the other hand is tied up with value judgements and with our actual practice of medicine and help seeking.

1.2 The program

I will briefly run through the general program of this essay which follows a dialectic that Derek Bolton has identified (Bolton, 2008). The thesis conceptualises mental disorder as a complete break with the ordered realm, that is, the realm of meaning, reason, truth and so forth. The anti-thesis is that there is meaning in all madness. What is going on in mental disorder is simply that there is an order that does not cohere very well with the dominant order of the day- for example, it could be argued this is what is going on in Attention Deficit Hyperactivity Disorder and the ethic of 'modern capitalism' and the ideal of the disciplined self. The synthesis which includes elements from both positions that has resolved this tension Bolton identifies as resting within the contemporary cognitive psychology paradigm.

I follow this dialectic by first of all looking at the writer Thomas Szasz. His critique suggests that there is no such thing as mental disorder as such, "mental illness is a myth". Szasz resists a particular picture of mental disorder. The problems that people present to psychiatrists are problems that are necessarily defined in relation to social, ethical and political norms. These are norms which medicine (as Szasz conceptualises it) does not have anything to say about. Ethical, political and social problems are the *kind* of problems they ought to be seen as, they are not medical problems. One response to this is to accept what the medical picture entails- it is independent of social norms, and maintain that many of the problems (although not all) that people present to psychiatrists can be defined in a manner independent of the social order. Wakefield and Boorse are two theorists I look at who attempt to trace this line of thinking. They both attempt to 'analyse' the concept of mental disorder, a project which is seen as characterising the natural fact that underlies the application of

the concept.

I argue that both Wakefield and Boorse fail to do this. I then go on to argue, following Derek Bolton, that the domain of psychiatry is not defined by the particular nature of the problems it deals with, but rather the particular way it responds to such problems. Mental disorder is linked with the social, ethical and political order(s), however, a shift in our representations of psychiatric conditions can accommodate this. This move in a sense completely undercuts the anti-psychiatry/naturalist debate in that there is no 'natural' domain here at all to characterise. The debate is undercut in a second way too in so far as a shift in our understanding of what mental health care is about, which takes into consideration the anti-psychiatry critiques, removes the impetus for trying to separate the medical from the social, the two are intimately linked. I argue for a relaxation of the dividing line between those with mental disorders and the rest of the population, between sanity and insanity. The closure of the asylums and the integration of the mentally ill into society is emblematic of this. I then look to Wittgenstein in attempting to make sense of this move, and to bolster the credibility of it.

1.3 Drury on madness and religion

To set the scene I am going to draw from an essay by the psychiatrist Maurice O'Conner Drury, a student and friend of the Austrian philosopher Ludwig Wittgenstein, titled 'Religion and Madness' (Drury, 1996). Drury experienced first hand the problematic nature of mental disorder and the practice of psychiatry. How ought I to see this person in front of me, how do I help them, and how do I prevent myself from being dismissive of another's way of getting on in the world? I will begin by looking at some problematic cases Drury presents before us. These cases exemplify the kind of problems and questions this essay is going to be concerned with which will provide us with some geography to explore, some texture.

Drury's worry was over the potential to confuse spiritual matters and difficulties for psychiatric conditions. The cases Drury describes show how difficult it can be to tell when (if ever) it is right to see someone's mental life or behaviour as pathological and in need of medical help and when to see it as a different kind of difficulty, one that is in need of a different kind of help and understanding, for example, spiritual, moral, or legal. In particular, the cases Drury discusses in his essay 'Madness and Religion' wrestle with the question of how to distinguish a genuine spiritual experience from those associated with mental disorder. Here is Drury:

> The first case I want to describe to you is that of a man aged fifty-four, a priest. We will call him father A. This priest had for some years been directed by his Superior to conduct retreats, a type of work for which he was considered to have great gifts. A few months prior to my seeing him he had begun to feel very depressed about his work, that he could no longer put feeling into what he was preaching; that he was asking people to believe and do things which he himself had lost faith in. It was a great burden for him to say mass or read his daily office. He felt that he ought never to have been ordained, that he had no vocation. When he visited his brother, a happily married man surrounded by his family, he felt *that* was the sort of life he was meant for. In addition he began to lose weight and to have very disturbed sleep, he would wake up at three in the morning and lie awake till dawn worrying about his spiritual state. He developed a feeling of great tension and discomfort in the pit of his stomach. He could not eat. These symptoms led him to believe that he had cancer, to hope indeed that he had cancer and that he would soon be dead. He consulted a physician who advised admission to a general hospital for investigation. After the usual X-rays and biomedical tests had been done he was told that there was no evidence of any organic disease. But he felt no better for this information. It was at this stage a psychiatrist was called in who diagnosed

> involutional depression, and recommended admission to a mental hospital for treatment. So it was he came under my care. When I first saw him he was resentful and suspicious. His condition was a spiritual one, he stated, and no doctor could aid him. He had brought it on himself and must bear the blame for it. I concentrated on his insomnia and his abdominal pain and asked him to let me treat these symptoms, leaving the whole question of his spiritual state in abeyance for the time being.
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> I gave him a course of what is known as electric convulsive therapy. It consists in giving the patient an anaesthetic and then passing a current of 150 volts for about one second through the frontal lobes of the brain. This causes a generalised epileptic-like convulsion which lasts about two minutes. Within fifteen minutes the patient is awake and fully conscious again.
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> After the first treatment the pain in the abdomen had gone. He began to eat better, he needed less drugs to obtain a full night's sleep. Within a week he came spontaneously to ask if he could say mass again. By the time he had seven such treatments he stated he was feeling very well. He was sleeping soundly without any drugs and had gained ten pounds in weight. But this is what is significant: his spiritual problem had disappeared too. He was saying Mass every morning, and could read his daily office again with devotion. He felt ready to return to his work and to conduct retreats as he did before. This is what he is now doing, though his Superior has been advised to see that he has proper intervals of rest(Drury, 1996, pg116-18).

It would seem that whatever Drury did was a success, that psychiatry, and the body of knowledge that grounds it has been employed to a good end. This, Drury informs us, is how he suspects most of his colleagues would have viewed this case, that is, as a straight forward case of involutional depression that has been effectively treated. Drury

on the other hand was not so sure that this is all that is going on here. Indeed, he tells us that this case raises for us important philosophical and ethical questions.

For what of those spiritual problems that the priest was suffering from? For surely it seemed as though the crisis the priest was going through involved a questioning of some of the deepest facets of human existence. Were they simply nonsense, the result of perhaps a chemical imbalance in the brain with no deeper or more significant meanings? With no real connections to the spiritual life? This is a question of where to correctly locate the problem. Drury thinks that it is not clear cut that what he treated was *solely* a medical condition, as opposed to a real spiritual crisis. Drury sees parallels between this case and the experiences the Russian novelist Leo Tolstoy writes about in his 'My Conversion'. He cites the following passage from Tolstoy:

> I felt as though something had broken within me on which my life had always rested, that I had nothing left to hold on to, that morally my life had stopped. An invincible force impelled me to get rid of my existence, in one way or another. It cannot be said that I wished to kill myself, for the force that drew me away from life was fuller, more powerful, more general than any mere desire. It was a force like my old aspiration to live, only it impelled me in the opposite direction. It was an aspiration of my whole being to get out of life. Behold me then a happy man in good health, hiding the rope in order not to hang myself to the rafters of the room where every night I went to sleep alone; behold me no longer going shooting, lest I yield to the too easy temptation of putting an end to myself with my gun. I did not know what I wanted. I was afraid of life; I was driven to leave it; and in spite of that I still hoped for something from it. All this took place at a time when as far as all my outward circumstances went I ought to have been completely happy. I had a good wife who loved me and whom I loved, good children and a large property which was increasing with no

> pains taken on my part (cited by Drury, 1996, pg118-19).

Drury tells us that if the same treatment he had used on his patient had been available at the time, this man's (Tolstoy's) two years of suffering could too have been alleviated. The question is, would that have been the right thing to do? For the thoughts and convictions that Tolstoy developed during this period and which came to eventually deliver him from this misery were to determine his whole future *manner of life* and writing. Here we are talking about a way of life with an attendant notion of the truth and of the Good. There are a number of similarities to 'Father A', enough to suggest that Tolstoy could have been diagnosed and treated for depression. The problem is that once we have done this are we not dismissing the spiritual here? For what if Tolstoy's new 'manner of life' resulting from these painful experiences is truer, more virtuous, more in tune with the nature of the Good than his former life? For surely there was meaningful content to his suffering that brought about such radical changes.

One way to interpret Drury's patient is to see his crisis as one between the values of a secularist outlook and those of a non-secular one. Is the ultimate good found within the kingdom of heaven, or is it to be found in an affirmation of ordinary human life, "I saw my married brother...". Our own manner of life can be seen as implicated because a radically different set of values to our own can form a manner of life that is incomprehensible to us. "Why on earth do they do that, starve themselves half to death?", we might wonder of an ascetic, "surely they are mad?", in need of help. Drury worried that we may be in danger of dismissing the spiritual, that we might blind ourselves to something important.

> But today it would seem a psychiatrist can treat such states of mind not out of the abundance of his spiritual wisdom and experience, but by mechanical and materialistic means: electrical stimuli to the brain, drugs which alter the biochemistry of the nervous system. Such treatments can be

> given by some recently qualified young man to whom the spiritual agony of the patient is something quite outside his comprehension.

Drury asks,

> Can we differentiate between madness and religion? Can we say of one such state: 'This is a mental illness and is the province of the psychiatrist? And of another: 'This is a spiritual experience sent by God for the advancement of the soul and is the province of a wise director?' (Drury, 1996, pg121).

Drury gives us more examples with a similar problematic. One of which is of a 67 year old retired civil servant who was a man of great piety who devoted his retirement to prayer and works of charity. His wife however did not look favourably upon this, regarding it as morbid religiousness. Drury tells us that

> one morning at Mass he heard read the words of the Gospel: 'Go and sell all that thou hast and give to the poor and thou shalt have treasure in heaven, and come and follow me'. These words spoke to him like a command. Straight away he left the church putting all the money that was on him into the poor box that was at the door. He set off to walk the 135 miles to Lough Derg, a famous place of pilgrimage since earliest times (Drury, 1996, pg124).

He eventually turned up and was seen by a doctor and put on a temporary certificate for admission to a mental hospital. He made no protest upon entry, told his story clearly and maintained that what had happened to him was God's will. Drury gave this man no treatment apart from insisting that he have breakfast in bed and be allowed to restore his emaciated frame. Drury tells us that he talked to him and that he learnt more from listening to him than the man did from him.

Drury reminds us that if we look back some 1600 years ago to a Church in Alexandria.

> Another man hears these same words read from an alter. And straight away he goes out into the desert around Thebes and lives there until his death a life of heroic austerity. Soon thousands are to follow him; to form themselves into communities, to draw up a rule of life. It is the beginning of Christian Monasticism with all that it was to mean for European religion and culture (Drury, 1996, pg125).

There is a deep connection here between these experiences and the roots of western culture that gave rise to many of the ideas and ideals that today shape our understanding of who we are, what there is, and what kind of life is worthwhile. It is interesting to note that in so far as our notion of the Good is deeply rooted in Christian monasticism, our notion of life well lived has its roots in the experiences of what many today would call madness.

What these cases show is the problem we encounter when we think about psycho-pathology in relation to spiritual concerns, whereby different ideologies can lead to different impressions of what is going on. This not only occurs between the secular and non-secular, but too within the secular domain. Leonid Plyushch, an advocate for democracy in the former soviet union is an example where confusions between the political and the pathological can be made. Or, as in this particular case, confusions can be abused for political ends ("Why would you want that, can you not see that to do that is to attempt to move against the tide of history, you must be mad!"). Leonid Plyushch was given a diagnosis of Sluggish Schizophrenia. It is thought that such a diagnosis was given with political considerations in mind. That it was used as a tool to prevent Plyushch from continuing his subversive activities towards the state and the powers that be. Various bits and pieces of his life, his diary, and what he said, were interpreted in such a way as to be said to be indicative of mental disorder (Wing,

1978). It is claimed that given a fair and rational assessment of his condition, no good doctor would have diagnosed him with a mental disorder. Although the sceptic may say that this is simply the assessment of western/capitalist psychiatry that fails to see the insanity in its own manner of life. A Soviet psychiatrist may claim that Leonid Plyusich was delusional in that he had failed to grasp the reality of the tide of history. This is one problematic and parallels the one mentioned above, namely of how to distinguish between a manner of life that is simply different, and one that is pathological.

There is also a political element to this Wing suggests. The problem with psychiatry in the Soviet Union was not so much that 'mental disorder' as such is a nonsense, but rather that the concept was being deliberately misused for a particular purpose. When there is a lack of judicial review and a second source of considered opinion where conflicting views can be debated reasonably, Wing argues, such a situation tends to lead to conclusions that are in line with those in power (Wing, 1978). It is not so much a confusion over whether or not a particular condition ought rightly to be considered as a medical condition, which is our principle problem and the one with which Drury grapples, but rather an example of unethical (unvirtuous) psychiatric practice and the abuse of power.

1.4 Options and answers

Drury considers the famous psychoanalyst Sigmund Freud's response to the problematic he is struggling with in cases such as the two of his I presented earlier. Essentially Freud takes a hard line secular and atheistic stance, claiming that there is no distinction between the pathological and the religious (as seen above), that is to say, for Freud, it is all madness. For Freud, Drury tells us, it is "obvious to anyone trained in psychoanalysis, that religious beliefs and practices are an obsessional neurosis(Drury, 1996, pg127). The lack of scientific belief for such religious beliefs and the conviction with which they are held

are seen as having a direct parallel with the beliefs a paranoiac holds and the way they will hold onto a delusion despite a complete lack of evidence, or indeed, evidence to the contrary. Or another parallel Freud would draw is between the strictness and repetitiveness with which a religious ceremony may be performed and the repetitive behaviour of an obsessive compulsive.

Drury finds such a response entirely unsatisfactory. The idea that knowledge ought to be restricted purely to engineering (the sciences) is one that is based on a hard atheist and secularist understanding of the world. The idea that science and the thought that what counts as 'evidence' is a neutral matter is itself quite controversial for it ignores the fact that what counts as 'evidence' is tied up with socially established forms of legitimisation. Forms that can be intimately tied to an ideology and a manner of life. That is, the public standards of what can count as verifying a knowledge claim. What counts as a legitimate claim is related to the society of the day. Go back 600 years and the idea that a message from God is a good reason to do something is seen as making a legitimate claim.

What a move like Freud's fails to see is that underlying it is an ideology, a notion of the Good. Failing to see this is in a sense a source of the problem itself Drury encountered, namely, that in the mental health profession we can see as pathological another manner of life because we fail to see how it could possibly make sense. And where could the conflict in understanding of life be greater than between secular and non-secular outlooks?

The problem that Drury sets up is one of where to draw the line between spiritual problems and medical ones. One way to approach this is to claim that a greater understanding of what mental disorder is would provide such a distinction. This is one way of trying to solve the problem Drury faces. The thought is that it stems from a lack of understanding of the true nature of mental disorder. A tripartite grouping can be made to the approaches towards what we are dealing

with here.1) The first is to deny that we should conduct ourselves by any notion of 'mental disorder'. This is to say that Tolstoy, and both of Drury's cases I mentioned above were all genuine spiritual affairs. To see these experiences as the result of pathology is to dampen the fire of life, to lose a part of human life that holds a place (at least for some) for true human flourishing. Or it mistakes moral, political, social problems, that ought to be seen as precisely those kind of problems, for medical ones. 2) The second is to claim that there is such a thing as mental disorder and that a principled distinction can be made between genuine pathology and spiritual affairs or indeed, simply the normal and healthy sphere of human difference and diversity. 3) The third is to say that it does make sense to talk about mental disorder, that it is a truthful and importantly to those suffering, helpful, field of human knowledge and practice. However, no principled distinction can be made as such. Insanity blurs and makes so many points of contact with human existence that the two cannot be separated in a way that gives us any easy answer to cases such as Drury's.

The movement of this essay will follow a dialectic that moves from 1 through to 3. Concluding that the truth lies somewhere along the lines of 3. 1 is a position that is taken up by the American psychiatrist Thomas Szasz who argues that the notion of someone being mentally ill is a myth, that is, 'mental disorder' is fundamentally a conceptually confused picture. I begin by looking at Szasz' arguments in order to help us give shape to the conceptual landscape we are exploring. I agree with Szasz in so far as we think of mental disorder in the form that he is critiquing, however, I argue that mental disorder as a field of understanding is not limited to what Szasz critiques. Essentially, Szasz, I claim, shows us what mental disorder should not be thought of as. I then go onto look at accounts of mental disorder that are formulated in the spirit of position 2. Jerome Wakefield (Wakefield, 1992a,1992b,1999,2000,2002) and Christopher Boorse (Boorse, 1996,1997) are two writers who believe a principled distinction can be made whereby we can say with reasonable surety whether or not, for

example, Tolstoy had depression (that is, if we could go back in time and gather all the relevant facts), or whether the priest that came to see Drury was suffering from an illness or was suffering from a spiritual crisis. This approach takes mental disorder to be a natural entity or biological fact. The problem according to Boorse and Wakefield is that we have failed to properly define what the concept is about. Once the correct definition is found, the thought is that we can clear up the grey areas of psychopathology. I examine this position but ultimately find it unsatisfactory, ultimately moving towards a position that is closest to 3. Derek Bolton (Bolton, 2008) I believe offers an account that runs along the lines of position 3, and is one that I attempt to move towards and offer arguments for. Bolton's position, briefly, is that what defines the field of psychiatry is not so much the nature of the problems it deals with, but rather, the way it responds to such problems. This is to say, the problems that people come to the mental health profession with are of incredibly diverse kinds, and that it is the particular kind of response to these problems that defines psychiatry, not the nature of the problems themselves.

Drury's answer to the problem he presents to us with such cases as the ones I have presented above is within the spirit of position 3. The question of whether or not person X is really suffering from mental disorder Y, or is rather simply suffering from a, for example, spiritual crisis, is one that is not worth pursuing:

> When in philosophy you keep coming up against a dead end, such as we have so far, in our search for a principle of differentiation between madness and religion, it is often because we are looking for the wrong type of answer. And this indeed is what I believe we have been doing in our search. For we were sitting back in the cool hour and attempting to solve this problem as a pure piece of theory. To be the detached, wise, external critic. We did not see ourselves and our own manner of life as intimately involved in the settlement of this question (Drury, 1996, pg132-33).

This is a conclusion that chimes well with that of Derek Bolton and is the one I will move towards in this essay.

2 Thomas Szasz and Medical Understandings of the Psyche

2.1 The myth of mental illness

The American Psychiatrist Thomas Szasz has written much on the topic of mental health care and the concept of mental illness or mental disorder. Szasz is representative of a certain form of critique of psychiatry and helps focus our attention on the problematic nature of mental disorder. In particular, his critique is essentially about the way a certain picture of mental disorder fails to fully track the reality of what is going on in people who come to the attention of psychiatrists. He does this by presenting us with two clear alternatives on what mental disorder could be. These, for him, limit the possibilities of what the term could mean. Both interpretations are problematic. Indeed, Szasz goes onto argue that there is no such thing as mental disorder. However, I will argue that this does not necessarily follow from Szasz' critique, rather, while not providing an argument to the conclusion that there is no such thing as mental disorder or illness, he does provide us with a persuasive argument against a *certain picture* of mental disorder, to borrow a Wittgensteinian motif.

Derek Bolton says of the anti-psychiatrist movement (as exemplified by Szasz, Foucault and Laing) that it sparked a debate that has, he believes, resolved itself in the cognitive processing paradigm that has emerged since then that has blurred the old dichotomies between mind/matter and meaning/causality in a way, and with an inevitability "that Hegel would have admired" (Bolton, 2008, pg67). It was dichotomies such as these that hindered psychiatry from understanding the individuals that it was trying to help. Szasz' critique, I claim, is principally directed at such forms of understanding the mentally disordered where such dichotomies still play a prominent role.

At the heart of Szasz' critique is the thought that the concept ‘mental illness’ dehumanises people (Fulford, Thornton, Graham, 2006). It strips the meaning from people’s psychological problems, and hence in a way, strips away the possibility of a meaningful response. From this point of view, the priest who Drury saw was not engaged in questioning the deepest aspects of our being, rather, he was simply depressed. His suffering can be conceptualised as the result of a chemical imbalance in his brain. We can see how this denigrates what for the priest was a real spiritual matter. It is important to notice however that being diagnosed with a psychiatric condition is not always viewed as a bad thing. It can be quite reassuring in that it allows someone who has been very troubled to rationalise what has been happening to them. "It's not just me, I have a recognised condition which affects others too and there are professionals who have been trained to help people with such conditions". This is a possible sentiment of someone diagnosed with a mental disorder, although, as Szasz claims there is no such thing as mental disorder, he would argue that such a sentiment is often unjustified.

Szasz conceptualises two possibilities for what mental disorder could be. Simply stated, either there is a physical disease, a brain disease, or mental disorders are actually simply people’s 'problems with living'. That is, the everyday social, political and ethical problems people have with living life, coping with the world and so on. The thought is that either someone’s physiology, neurology, or neurochemistry is diseased, that is, for Szasz, there is the presence of a physical lesion or abnormality (a disease entity), in which case, *that* is where we are to locate the concept, or, there is no disease, and what mental disorder is really picking out is simply someone's difficulty with getting on in the world. Either way, Szasz concludes that the notion of someone being mentally ill is a myth, or is merely metaphorical. No one can actually have a disease of the mind. Disease is not something that can be applied to the mind, it is a strictly somatic concept.

Szasz's argument rests on a particular understanding of what it is that medicine is concerned with and the forms of understanding and knowledge it has at its disposal. If an assertion of mental disorder is to fit within a medical framework then it must be about some kind of diseased entity which for Szasz takes the form of a physical lesion, an objective fact of the natural world that is independent of any social norms, value judgements, or cultural interpretations. However, Szasz suggests that many of the problems psychiatrists do encounter do involve social norms and values meaning that psychiatrists are not really dealing with any kind of medical condition at all. Rather, what they often see in the clinic are people's problems with living. A medical understanding ignores the social and moral elements, including all the meaningful connections that are involved in peoples everyday difficulties with getting on in the world. As a result a medical representation of such matters utterly fails to account for what is actually going on, in fact, it blinds us to the fact that they are actually social, ethical, political, or even spiritual matters. Such blindness delegitimises or dehumanises another and their beliefs.

I will run through his basic argument (Szasz, 1960) with the goal in mind of giving a sense of the motivation for the naturalistic response, in particular that of Boorse and Wakefield who have both offered compelling theories on how we can talk about and ground illness/disease and mental disorder in a naturalistic fashion, that is, independently of social norms. Szasz's critique rests on a set of assumptions that I will critique as I look through the two understandings of mental disorder he presents to us: mental disorder as 'brain disease', and as 'problems with living'. In doing so I hope to destabilise this dichotomy he presents to us.

2.2 Mental illness(disorder) as brain disease

Szasz argues that mental disorder construed as brain disease has nothing to do with disorder of the mind. Brain diseases are physical

diseases (which for Szasz, is the proper domain of medicine). Szasz's reasoning is that mental disorders are defined against psychosocial, ethical, and legal norms, brain diseases are not defined by such norms, therefore, mental disorders are not brain diseases.

Szasz's understanding runs along the following lines. Taking the notion of bodily disease as paradigmatic, disease being an objective, natural fact, a physical aberration to which we can point, we are lead to a line of thought that suggests we could make sense of mental disorder by conceptualising it as having its basis in neurological defects or lesions. The outward symptoms may be in an individual's behaviour and manner of speaking, in how they live, but this only indicates to us that something is physically wrong with their brain. We equate mental disorder with brain diseases or neurological defects, and thus we see with this picture mental disorder as on a par with somatic illness and disease. Szasz correctly points out however that if this were the case, "the concept of mental illness is unnecessary and misleading" (Szasz, 1960, pg21). For what we appear to be now talking about is simply a bodily disease which can in theory be defined with sole reference to the state of one's brain once that particular defect has been identified and studied. Mental disease becomes physical disease, making the former redundant as it is subsumed under the latter, that is, mental disorder as a concept is redundant because all it really is is a type of brain disease. The myth of mental illness is that the kind of conditions that psychiatry deals with are essentially of a kind with what the rest of medicine deals with, that psychiatry is (bio)medicine of the mind.

To think of mental disorder as brain disease means to think of it as essentially disordered, meaningless, and quite amenable to the biomedical model, the cause of the person's problems here are strictly located in an aberrant brain lesion. The focus of medical intervention is in removing the abnormality, and restoring the person's brain to a normal state. Neurosurgery, for instance, is a field of medicine that can help heal a person suffering from brain diseases.

If we are to equate mental disorder with brain disease, it is thoroughly misleading to talk about mental disorder at all, for what we are actually talking about are diseases of the brain, physical abnormalities, not psychological or social abnormalities (although these may be the result of brain diseases they are certainly not the cause of them, so the argument goes). The idea here is that we do not, at least in theory, have to refer to people's outward behaviour to identify brain disease. Although, of course, as brain diseases can lead to changes in someone's behaviour such that that behaviour may be the impetus for an investigation of someone's brain, it is in the end possible to identify a brain disease without ever referring to such behaviour. Szasz concludes that mental disorder cannot be equated with brain disease because the two are defined in completely different manners. Brain diseases are defined in an objective factual manner through the presence of a lesion, while mental disorders are defined against psychosocial, ethical and political norms.

Brain disease however is not quite as straight forward as Szasz makes it out to be. For Szasz, picking out a defect in the brain is relatively unproblematic as he adheres to a ’lesion’ account of disease. Knowing whether there is a disease or not is a matter of noticing a disease entity much like one notices there is a table in a room. One simply identifies the presence of a lesion, something that ought not to be there, or is not there but ought to be, or is different. We identify an object, which can be done scientifically and in a way that is completely independent of social norms and cultural interpretations. With brain disease, this can in theory be done without ever referring to an individual's outward behaviour, that is, independently of an individual's ability to live well socially, morally, or legally speaking. This ‘lesion’ account of disease is potentially quite inadequate for characterising disease. For Szasz disease is a value free, objective fact of nature. However, it seems difficult to characterise disease simply as the presence of a lesion. How is such a lesion defined? Are not value judgements, at least perhaps the most basic one of harm somehow involved in identifying

a lesion? For example, the notion of function or process may be crucial to understanding disease. Applied to the brain, the brain disease itself may only have been picked out in the first place due to symptoms (a perturbed function) that present themselves in the social world.

Underlying Szasz's thought is the idea that the domain of medicine ought to be defined in terms that are independent of the social order. I agree with Szasz that mental disorders can not be conceptualised as brain diseases, however, I disagree with his reasoning to this conclusion. Szasz argues that the two are not the same as one, brain diseases, are objective factual matters of fact, whereas, the kind of things psychiatrists deal with are socially and culturally defined. This brain disease/objective vs mental disorder/culturally relative distinction however falls apart upon closer examination. In what follows I will look at some of the tensions such a distinction encounters.

Psychiatry can, under the auspices of the biomedical model, have a tendency to understand mental disorder as reducible and wholly circumscribable and explainable as brain disorder. This is to emphasise the disordered, causal aspect (physical or mechanical mechanisms) over the meaningful/ordered (potentially understandable) aspects of mental disorder, a tension and a dialectic that has been playing itself out over the history of madness. An equation of mental disorder with brain disease is not new. *The Oxford Textbook of Philosophy and Psychiatry* describes 'psychiatry's two biological phases' (Fulford, Thornton, Graham, 2006, Pg152). The first phase began during the nineteenth century where causal theories began to appear that sought to discover the biological basis which underpins mental disorder. In particular, in this phase a neurological basis for the major psychoses was the object. William Griesinger who was professor of psychiatry at the University of Berlin during the 1860s coined the phrase "Mental illness is cerebral illness" (Fulford, Thornton, Graham, 2006), an uncompromising phrase that seeks to

understand mental disorder as a biological/anatomical phenomenon. Karl Jaspers during the early part of the 20th century questioned this purely biological picture of mental disorder and emphasised that we should take into consideration both the causal explanations of mental disorder and those that connect mental disorder to the world of meaning and order. He held that there are elements that are captured by the biological sciences but that we should not let this blind us to the meaningful and potentially understandable facets of madness. Freud and psychoanalysis can be seen as a prominent attempt at understanding mental disorder that sees it as amenable to meaningful explanations whereby the aberrant experiences and behaviours of the patient can be seen as the expression of conflicting mental contents, consisting in beliefs, wishes, desires etc.

The second phase is what has developed since the 1950s, which has been built on genetics and neuro-imaging techniques, starting with the remarkable success of psychopharmacology in treating the major psychoses with drugs such as lithium for hypomania and chlorpromazine for schizophrenia. This success came as a surprise to many, in that it was a treatment of a chemical nature that had such a successful and marked affect on the major psychoses, as opposed to a deeper understanding of the psychological processes involved (Drury, 1999). The success of this approach has spurred on the biological understanding of mental disorder, which for example can be seen in a review article entitled 'Catching up on schizophrenia: Natural history and Neurobiology' (which opens with the line "Schizophrenia is a brain disorder that is expressed in the form of abnormal mental functions and disturbed behaviour" Lewis, Lieberman, 2000, pg325). The article reviews our current understanding of the genetic factors involved and the neuro-physiology and chemistry that is associated with schizophrenia. Caution is needed in that simply because we can identify differences in the brains of people with psychiatric conditions it does not necessarily follow that such conditions are therefore objective facts of nature, independent of social, ethical and political judgements and interpretations.

The tendency I am describing is to think of schizophrenia and mental disorder in general where we have found a cerebral identifier as *just* a neurological defect, as something that can be identified simply by looking at someone's brain, 'see that, *that's* a neurological defect' *that* is the cause of mental disorder'. Szasz objected to precisely this point. Mental disorders are not identified solely by looking at someone's brain and identifying abnormalities, rather, they are identified by looking at how someone acts, thinks, and behaves. What are found in the *DSM* and *ICD-10* are not descriptions of various brain abnormalities, but rather detailed and explicit descriptions of various social problems. For example, 'conduct disorder' is characterised in the *DSM* by, "A repetitive and persistent behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past twelve months, with at least one criteria present in the past six months"(American Psychiatric Association 2000, pg68). There is a list of 15 criteria which includes such things as:

-Often bullies, threatens, or intimidates others.
-has forced someone into sexual activity.
-has deliberately engaged in fire setting with the intention of causing serious damage.
-has broken into someone else's house, building or car.
-is often truant from school, beginning before age 13 years.

Einstein had a number of interesting and significant brain differences when compared to a control group of 35 males who had 'normal' neurological and psychiatric status. Such differences are thought to be linked to his exceptional intellect (Witelson, Kigar, Hervey, 1999). The question is, how do we define what the healthy human brain is meant to be? Mere difference, or the presence of an abnormality (lesion) does not seem sufficient to delineate a brain disease. No one would suggest that in hindsight Einstein should have undergone neurosurgery to correct these abnormalities. When we identify mental

disorder we do not first of all look at someone's brain, and by this identify them as having an illness, rather, first of all we identify someone as mentally disordered through their behaviour. As Szasz put it, "The notion of mental symptom is therefore inextricably tied to the *social"* (Szasz, 1960, pg21). For example, if we say that someone is delusional, that they have false beliefs, it is not by looking at their brain that we identify them as having a delusion. An example Szasz uses is that of someone who believes they are being persecuted by the Communists. By what light do we judge this belief to be delusional? Whether this person's belief is delusional is going to be with reference to the social world. The question we ask is: are they actually being persecuted by communists, do they have a legitimate claim here? We make a judgement with reference to what it is normal or understandable to believe around here.

To identify mental disorder simply by reference to abnormal brain states there must first of all be a judgement that there is something wrong with how the person is living and a subsequent connection made between that and the individuals brain. We could perhaps take homosexuality as an example which was diagnosed in the earlier editions of the *DSM* but was subsequently removed (Kutchins, Kirk, Kirk 2003). This removal as a purely logical point, had nothing to do with the brain states of homosexuals. There could in principle be very real and possibly significant differences in brain anatomy and/or physiology between heterosexuals and homosexuals, but this in and of itself is not sufficient to identify homosexuals as suffering from an illness, in fact, not only is it not sufficient, it seems irrelevant. First of all we identify a behaviour, belief, way of living as somehow harmful, and then we may perhaps look to underlying causes in the brain, but it doesn't work the other way. Whether or not a brain state is pathological in relation to mental unwellness has to start with, and therefore can not get away from, the observation that something in this person's mental/social life is not going well. This seems to break down the dichotomy between the physical (independent of the human order) and the mind (the social order).

Szasz is correct in arguing that mental disorders are defined against the social world, that they cannot be conceptualised and defined as solely a problem of the brain. However, he is incorrect to contrast this with what he understands to constitute real medical conditions which are defined objectively in a manner independent of the social world. I suggest that both are defined with reference to values we hold, as the case of Einstein's brain demonstrates.

2.3 Mental illness (disorder) as 'problems with living'

Because mental disorder, according to Szasz, is necessarily defined with reference to someone's behaviour and beliefs he concludes that 'mental illness is a myth' or merely metaphorical (Szasz, 1960,1994). It is a myth because *that's not what medicine ought to be, or is about*. The purview of medicine, according to Szasz, and this itself is a contestable point (Sedgewick, 1973), is and ought to be defined according to strict norms given in anatomical terms conceptualised as the presence of a lesion or abnormality, something that is independent of social norms and values. Szasz concludes from this that "The definition of the disorder, and the terms in which its remedy are sought are therefore at serious odds with one another" (Szasz, 1960, pg22). What psychiatrists are really dealing with are non-medical problems, that is, simply people's problems with getting on in the world. This however, as I have argued rests on an assumption that all true medical conditions are defined in a manner that is independent of the social order.

Although Szasz may be incorrect with his characterisation of real medical conditions as factual/objective and value free, he is correct in pointing out that we ought not to think of the kind of problems people present to psychiatrists in this manner. For in doing so we blind ourselves to fully understanding the nature of the person's problem.

Szasz wants to argue the problems people present to psychiatrists are the kind of things that one, for example, *learns* to overcome, however that may be done-a matter of responsibility-, or perhaps the problem is located within a wider social context- in which case perhaps we ought to be using the language of politics. For example Attention Deficit/Hyperactivity Disorder (ADHD) involves symptoms such as "often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort" (such as school work, homework, or writing a thesis), a symptom of inattention, and for hyperactivity, "often talks excessively", a symptom of hyperactivity (American Psychiatric Association, 2000). Of course, just these symptoms would not be sufficient to warrant a diagnosis of ADHD, although the rest of the criteria are of a similar nature. For Szasz, someone who is unable to function well in a classroom setting because they lack the ability to concentrate and focus does indeed have a problem. What Szasz would object to is the notion that we should think of this as a medical problem where a medical response is appropriate. Rather, we should think about this as, for example, perhaps simply a lack of discipline in the child that is exhibiting such behaviour, they need to learn how to function well in a classroom, they need to exercise some will power, some self-control. To medicalise the problem, Szasz would suggest, is to remove all responsibility from the child (and we could add the parents) to act in the world in such a way that they live well (a question of ethics (how to live well), not of medicine). What is obvious here is that certain social conditions and cultural interpretations of the Good may be implicated in seeing the child's behaviour as bad. Another question is whether the social conditions, where one is expected to sit in front of a desk, be quiet, and take in information is one that is suitable for everyone. Perhaps the demands on children are too much. This in itself is an incredibly complicated issue, the point that Szasz wants to make is that *these* are the appropriate kind of questions and potential responses to the problem characterised by ADHD, involving moral, political, and ethical understandings, not medical ones.

The same reasoning Szasz would extend to all the other conditions categorised in the *DSM,* that is, they are all social, political or moral problems, unless the basis is found to be from a 'real' disease of the brain, in which case, it should anyhow be understood simply as a brain disease.

2.4 Can we go on with our psychiatry with Szasz in mind?

Szasz' critique seems to leave psychiatry in a rather awkward position. It is certainly not simply a branch of neurosurgery, dealing simply with brain abnormalities, that is, thinking of mental disease as cerebral disease. It seems to be clearly dealing with conditions that are related to proper function relative to psychosocial, ethical, and legal norms-things which, Szasz claims, medicine has nothing to do with. The distinction here is between neurosurgery which deals with objective, value free, brute matters of fact, such as for example a brain haemorrhage, whereas, on the other hand, psychiatry is engaged with subjective, value laden norms of what counts as proper function in the social world: that is, with problems with living. The medical form of understanding, while being quite appropriate to the former, is totally misplaced when applied to the latter, so Szasz' argument goes.

Szasz's critique is successful only in so far as we accept a certain representation of psychiatric conditions, and a set of assumptions and dichotomies between the mental and the physical. I have been critiquing these dichotomies as I have presented Szasz's position.

In the present chapter I will question Szasz's assumptions along the following lines. Firstly, there is a difficulty in distinguishing between mental problems and bodily problems in such a way that this distinction could be drawn along the lines that parallel the distinction between objective facts of the body and culturally relative facts of the mind. Secondly, Szasz' picture of what it is that medicine is, and what it means to call something a medical condition is too limited. When

Szasz suggests that seeking a remedy to a problem with living along medical lines is totally inappropriate, I suggest, this is because he accepts a picture of medicine that is indeed inappropriate if applied to the mind. However, given a different understanding of what it means to call something a medical condition and a different understanding of the myriad forms medical remedies can take, then the medical responses can be appropriate to many of the conditions psychiatry, and the mental health profession at large attempt to help with.

Regarding the first point, Peter Sedgewick argues that the notion of disease is necessarily defined with reference to values (Sedgewick, 1973), the only difference between the mind and the body is that the norms of bodily function are fairly widely established and agreed upon, whilst norms of social functioning are more precarious. Both are value laden. There is less controversy over medicine that deals with our physical body simply because it rests upon norms that are more widely shared. Books on physiology refer to norms that are fairly uncontroversial, to goods we readily find common ground upon, such as that for example it is a good to have a heart that is able to pump blood around ones body, or that it is a good to be able to secrete insulin and take up sugars into one's liver, muscle and fat tissues. However, some norms that are found in textbooks on psychiatry are arguably of a kind such that common ground can less easily be found simply because the norms, rather than relating to the physical function of the body, relate to the mind and all its attendant connections with social, ethical and legal norms. Such as, for example it is a good to form and enjoy close relationships with others, express ones emotions and so on.

Cooper too suggests that both health problems of the mind, and those of the body, can be potentially controversial in terms of defining the domain of medicine. She gives the example of cochlear implants given to deaf children, which seems to imply deafness is a disease state. Someone who is deaf, while not being able to hear, lacking that ability, skill or sense, may have developed other skills to get on in the

world (Cooper, 2007). Members of the deaf community have argued that the labelling of deafness as a medical condition is an affront to deaf culture. The question of whether they are truly diseased or not is not amenable to a straight forward answer. It seems a bodily disease could be linked to social and ethical norms, that is, linked to an understanding of the Good.

Regarding the second point. The domain of psychiatry is concerned with people's problems with living, that is, it is inherently defined in terms of people's behaviour, with how they get on in the world. What Szasz does show us is that we ought not to think of mental disorder using the picture of illness as the presence of a lesion, whereby the phenomenon that health professionals set out to treat is seen as a reified cause of the phenomenon itself, and thus ignores the social world in which such problems can be understood. As though mental disorder were some kind of material entity that some people harbour that causes them to be mentally disordered. This is to say, do not think of mental disorder as say like a bacterial infection that can be caught, transmitted, is essentially meaningless, disordered, and therefore the medical response is unproblematic, or the *only* response that is appropriate. For if this is the case, we are not really talking about mental unwellness, rather, this would simply be a physical disorder (mental disease as brain disease). These problems do exist Szasz does admit, it is simply a certain picture (in the Wittgensteinian sense), model, or way of seeing a particular phenomenon, that he is resisting. One that sees mental disorder as essentially like physical illness, for if this is the case, 'why not just call it 'physical disorder'?', if not, then we ought to drop this picture, namely that of these problems with living as being essentially analogous to bodily illness.

2.5 Representations of disease

The idea of a particular 'picture' of something is important here and is worth elaborating on. It is a thought I am drawing from Wittgenstein's

Tractatus-Logico-Philosophicus. It was used by Wittgenstein in an investigation of language and the relation between a proposition and the world, or the truth. A picture in this sense is a representation of reality, a model (Wittgenstein, 1999, pg10). We build such models for ourselves in order to come to grips with reality. Such a picture for Wittgenstein is said to mirror the logic of the world, that is to say, it arranges a number of basic elements (atomic facts) in such a way that it corresponds to the way such elements are arranged in the world. In this way a picture "is linked with reality: it reaches up to it" (Wittgenstein, 1999, § 2.1511). The logic of our language, in terms of relations and consequences, mirrors the logic of the world. A picture is a way of conceptualising a particular part of the world such that it shapes how we see something, of course, the logic of our language may not reflect the logic of the world totally accurately.

Key here is the idea of representation. Wittgenstein was influenced in these thoughts by the physicist Heinrich Hertz, who in his *Principles of Mechanics* carried out an investigation in to the nature of scientific explanation. Hertz emphasised the notion of model building. We form pictures (Scheinbilder) of external objects with the goal of matching the deductive consequences (logical relations) of our model or picture with that of the facts (Hacker, 1986, ch.1). In building such models we often use analogy and metaphor. We use one way of thinking that we are familiar with and apply it to a new area so as to gain insight and understanding of a new domain. For example, in coming to grips with the notion of energy, Hertz claims our understanding of it is drawn from an analogy with our notion of substance. We think of energy as a substance that has an independent existence, can be seen to be at a particular place at a particular point in time, and that through all its changes retains its identity.

With such picture building sometimes the model holds certain contradictions and inconsistencies, and that although it may help us to come to grips with a phenomena, it may also hinder our understanding by blinding us to other potential pictures or understandings of what is

going on. Szasz can be understood as claiming this of the notion of 'mental illness'. When it comes to potential energy, the analogy seems to loose some of its coherence, "the concept of potential energy has no counterpart in a substance" (Christiansen, 2006, pg8-9). Ludwig Boltzman, another seminal influence upon Wittgenstein, saw such analogies as something that need not be rejected if it fails to find perfect agreement with the facts. We see this in his theory of electricity which provided insight through productive mechanical models which were made through analogy (Hacker, 1986, ch.1). Think of electricity using the language of mechanics.

With the concept of force, again Hertz carried out an investigation that proposed to help understand why physicists had as yet been unable to discover the *true nature of force*. The naturalists, who I will look at in the next chapter, attempt to do just this with regards 'mental disorder'. Boorse and Wakefield understand their respective theories as discovering the *true nature of disease*. Here we see what Wittgenstein saw as a concise account of how a picture we have of something can confuse us and lead us into asking questions of which no answer can truly satisfy. Again, part of this can be thought of in terms of the relations that hold within our picture of force and what analogies we use in our understanding of it. For example, muscular force has a number of relations to that of our concept of force in mechanics, but it seems that the notion of action at a distance is quite alien to our everyday understanding of force (Christiansen, 2006). Here is Hertz in his *Principles of Mechanics*:

> We have accumulated around the terms 'force' and 'electricity' more relations than can be completely reconciled amongst themselves. We have an obscure feeling of this and want to have things cleared up. Our confused wish finds expression in the confused question as to the nature of force and electricity. But the answer which we want is not really an answer to this question. It is not by finding out more fresh relations and connections that it can be answered; but

> by removing the contradictions existing between those already known, and thus perhaps by reducing their number. When these painful contradictions are removed, the question as to the nature of force will not have been answered; but our minds, no longer vexed, will cease to ask illegitimate questions (Hertz, 2004, pg7).

Above, when I mentioned that Szasz is 'simply resisting a certain picture', what I had in mind can now be made clearer. The thought is that our understanding of the problems that people present to mental health care professionals have been shaped by drawing an analogy with our understanding of physical illness and disease. The picture of mental disorder I claim Szasz is rejecting is one that draws too heavily upon, and makes too many parallels (at the expense of any others) with that of our understanding of physical illness and disease. That is, a picture of mental illness that is shaped too much by our understanding of physical illness. Such an understanding fails to adequately fit the facts, or to put it another way, the logic of such a conception of mental disorder fails to successfully track the logic of the reality of what it is psychiatrists and other health care professionals encounter in the clinic.

Szasz convincingly argues that questions of values, what counts as living well, and therefore what counts as living unwell, play an integral part in identifying the kind of things psychiatrists deal with. This is to say that psychiatry is not defined by value neutral terms, meaning that we should therefore acknowledge the moral aspects of psychiatry. Indeed Szasz tells us that he sees this as one of the main points to his argument, "to criticize and counter a prevailing contemporary tendency to deny the moral aspects of psychiatry (and psychotherapy) and to substitute them for allegedly value-free medical considerations" (Szasz, 1960, pg25).

Those who think psychiatry is in certain circumstances an appropriate response to people's problems with getting on in the world argue that

Szasz's position rests on questionable assumptions about what disease, health and medicine are, and therefore the kind of problems a medical understanding can be of some help with. Important here is 'some help'. Here we have an intimation towards a refrain that I will make throughout this essay. Wittgenstein, when presented with a textbook that provided the basis for psychiatric hospital treatment by M. O'C. Drury was quite impressed with it, "I like the spirit in which it was written... I can quite understand that you would adopt the attitude 'let's see now what these methods of treatment will accomplish'", referring to the recent advances in the treatment of the major psychoses. However, he warns Drury, "I don't want for one moment to underestimate the importance of the work you are doing, but don't ever let yourself think that all human problems can be solved in this way" (Drury, 1996, pg152). The moral here is that this is only one particular way of looking at what is going on here.

2.6 Medical representations and the mind

Szasz resists a certain picture. In this section I look at what some of the conceptual possibilities are that Szasz ignores. George Canguilhem, in his *The Normal and the Pathological* carried out an investigation into the different ways of thinking (representations or pictures) about sickness and health. He identifies two over arching representations of disease that "medical thought has never stopped alternating between" (Canguilhem, 1996, pg41). This is between ontological representations and functional representations of disease. This contrast is given form by marking a distinction between Egyptian and Greek medicine. The thought is that Egyptian medicine "probably universalised the Eastern experience of parasitic diseases by combining it with the idea of disease possession" (Canguilhem, 1996, pg39). With parasites, there is a discrete entity that enters the body, we can see it, the problem can be localised to that entity. Our therapeutic efforts are to be focused on the removal of the offending entity, "Throwing up worms means being restored to health", here, "disease

enters and leaves man as though through a door" (Canguilhem, 1996, pgpg39). The germ theory of disease is a powerful theory that embodies such a representation of disease. Greek medicine, in the Hippocratic writings and practice reflects quite a different understanding of health and disease. Here we see not an ontological but dynamic or functional understanding of health and disease, totalising rather than localisationalist. This is to say, health/sickness is seen as encompassing the whole person. Our nature is in equilibrium, a harmony of four humours, a disturbance to which leads to sickness. Disease is not seen as an entity at a particular location within us. Therapeutics here imitates natural medicinal action so as to restore an equilibrium. While deficiency diseases and all infectious or parasitic diseases tend to favour an ontological picture of disease, endocrine disturbances and all diseases beginning with *dys*- tend to favour a functional or dynamic picture. We see this especially with diseases relating to physiology (as opposed to anatomical health problems).

Szasz seems to limit understanding of pathology to ontological representations. The movement of his thought traces the following trajectory. If we take an ontological representation of disease and use it in our thinking about the kind of problems that psychiatrists, and indeed the mental health profession in general, including psychoanalysts and psychologists, deal with, then we are indeed going to misunderstand the nature of such problems. *That* picture is inappropriate. Because psychiatry is part of the medical profession and the medical profession is defined by such ontological representations, then any and all possible medical understanding of the problems psychiatrists have been confronted with must rest upon a misunderstanding of what is going on. This move only works however if we take an ontological representation as exhausting the realm of medical understanding. However, as we just saw with Canguilhem, such ontological representations of disease do not set the limit to medical understanding.

To pre-empt and give a sum to the movement of thought I am

attempting to track here, Szasz limits medicine to a particular understanding of disease and what medicine is. Szasz's critique is compelling in so far as it critiques a particular picture of mental disorder. One where the ontological picture of disease is applied to the kind of problems that psychiatrists are presented with.

Jerome Wakefield has questioned the assumption Szasz makes about our understanding of illness and therefore his reasons for thinking that a mind is not something that can be ill, or at least in a state where the medical response may be of some use. This is the assumption that is implicit in Szasz' reasoning behind why to talk of mental disorder is to talk metaphorically. This is that an ontological (or lesion) understanding of pathology sets the limits to, and defines medical understanding and representations of disease (as though one could 'throw up' a mental disorder Szasz wants to say). It is true that we cannot throw up a mental disorders in the way that one can throw up worms to restore health. But, one cannot throw up diabetes either in order to restore health. Physiological diseases, as Canguilhem points out to us, favour a functional or dynamic understanding of disease, rather than an ontological or lesion account. Here, we don't look for the presence (or indeed absence) of some entity or structure (anatomy), but rather for the dysfunction of some system.

I have mapped here the 'parasite/germs' Vs 'equilibrium' approach onto the Anatomical/Lesion Vs Functional approaches to understanding disease. Although there is not complete congruence between the two, there is a strain of understanding that splits both in a similar fashion. Both anatomical and parasite approaches take disease to be a discrete entity which can be physically localised to a particular location within the human body. Functional and equilibrium representations of disease don not conceptualise disease as a discrete localisable entity, but rather do so in a more holistic manner. The conditions that are listed in the DSM for example, are more amenable to representations of health and disease that run along the lines of the latter, rather than the former.

Once we start talking about function and dysfunction, Jerome Wakefield argues that it makes sense to talk about function and dysfunction in relation to people's psychological capacities, that medical representations can be applied to such things coherently. Boorse makes a similar point when he tells us that the controversies over what constitutes a mental disorder stem from the "unwillingness of mental-health theorists to take physiology as a paradigm" (Boorse, 1976, pg61). Such a representation of health and disease in terms of processes and functions, for Boorse derived from physiology, "shows no partiality for body over mind. Physical health is simply a special case obtained by focusing on the functions of physiological processes". He goes onto suggests that "Mental health, then, would be the special case obtained by focusing on the functions of mental processes; and there is such a thing as mental health as there are mental functions" (Boorse, 1976, pg61).

2.7 Representing medicine of the mind

We use a different representation of disease from the one we use when we are thinking about things like parasites, or bacterial/germ infections, or indeed, the kind of thinking we employ when we are dealing with a broken leg or a damaged liver. Health of the mind can be defined in terms of functions and processes of the mind, but in doing so we seem pressed to couch healthy psychological functioning in psychosocial, ethical, and legal norms. However, this, both Wakefield and Boorse suggest is not necessarily the case. Both argue that there is a value free way of defining what counts as natural human psychological functioning in a manner that is objective and scientific and therefore free of ideology and any particular understanding of the Good. They claim their approach avoids the criticism that psychiatry acts as a form of moral police force.

What I am moving towards here is an acceptance of Szasz, agreeing that psychiatric diagnoses are inextricably tied to the social world, but

that, *pace* Szasz, we can go on talking about mental illness, mental disorder, or mental health problems. We can do so by using medical representation of healthy functioning in relation to our psyche. The worry that arises once we accept what Szasz has to say is that we will be lead down the road of imposing a notion of the Good on those that may have other ideals- a sort of ideological hegemony. This can take a number of forms, one is the concern over the pathologising of the human condition, or simply the problems one encounters in life. To see these as medical problems, the thought goes, is to potentially ignore the moral, political, social and perhaps even religious aspects that may too play a role in the kinds of problems the mental health profession encounters. This is precisely the conundrum we saw Drury grappling with at the beginning of this essay. The question by what standards do we differentiate the pathological from the normal. Or, put another way, when is the medical response appropriate to someone's problem with getting on in the world, problems which the DSM and ICD-10 characterise and catalogue, and in addition, what kind of problems should be considered for entry into such catalogues?

Having accepted that mental disorder is not bodily illness vis-à-vis disease as the presence of a physical lesion, I have argued however that medical representations can plausibly be applied to the human psyche if we do so using functional language.Think of the mind as a system that carries out certain functions. We can apply medical representations by using the picture of physiology and applying that to the mind (Boorse, 1976). By characterising the mind as a system of normal mental functions, we can conceptualise pathology as deviancy from these functions.

We are left with the problem of differentiating between a dysfunctional mind and a mind that works in a way that we find difficult to comprehend but is not diseased in the sense that it is a system that has fallen apart. This, again, is the problem we saw Drury attempting to answer earlier. For are these now not problems that ought to be thought of in ethical and political terms, as Szasz would

argue. Should we not drop our medical representations altogether? Not only this, an anti-psychiatry critique would suggest that we risk ideological hegemony if we start talking about 'healthy psychological functioning', pathologising alternative ways of living (and hence denigrating them). One way of dealing with this is to say that there is still some fact of the matter that separates 'problems with living' where a medical understanding is appropriate from problems where other understandings of what is going on are better. This would be something that, thinking of the cases Drury describes, as differentiating definitively between spiritual and medical problems. Boorse and Wakefield are two theorists who attempt to do just this, that is, give an account of what healthy psychological functioning must consist in. It is to this approach that I now turn.

3 Naturalism: Mental Disorder as Biological Fact

"Diseases are new ways of life"
-George Canguilhem, *The Normal and the Pathological.*

"(*Tractatus Logico-Philosophicus,* 4.5): "The general form of a proposition is: This is how things are."- That is the kind of proposition one repeats to oneself countless times. One thinks that one is tracing the outline of the thing's nature over and over again, and one is merely tracing around the frame through which we look at it."
-Ludwig Wittgenstein, *Philosophical Investigations §114.*

Having suggested in the previous chapter that a notion of the Good is tied up with the conceptualisation of disease, and that a functional/equilibrium understanding of disease is potentially amenable to thinking about the health of someone's psyche, I will now look at two theorists who take up a functionalist account of disease but who claim that disease can be defined in a value free and objective manner. These are naturalist accounts of disease. I find that both accounts are problematic. The difficulty that such theories continually come up against is that the social and the biological are both intertwined to such an extent that it becomes difficult to make sense of the notion of 'natural' human psychological functioning. I then move to the thought that mental disorder, being intimately tied to the social world, can only be thought about using such norms. I defend this move against the critique that such a move risks pathologising mere difference by suggesting that this is only a problem under a *certain understanding* of what it means to call someone mentally disordered.

3.1 Preliminaries to naturalism

Naturalist thinking about disease is grounded in the attempt to give a value free account of natural function against which the pathological

can be defined. The problem is one of how to make sense of the difference between the pathological and the normal with regards psychological functioning. Derek Bolton states the problem thus, "what is the basis of the standards or norms by which we judge that a person has a mental disorder-that the person's mind is not working as it should, that their mental functioning is abnormal?" (Bolton, 2008, xiv). Essentially, what Boorse and Wakefield attempt to provide is an account of 'not functioning as it should' in an objective, value free manner.

Wakefield and Boorse conceptualise their respective projects as uncovering the true nature of mental disorder or revealing the underlying reality which underpins our judgements of pathology. The emphasis is on finding the right definition of mental disorder through conceptual analysis. We have this concept 'mental disorder' so there must be some thing or object (independent order) in the world to which this concept rightly fits. Once we have the right definition of mental disorder we will then be able to, for example, say of the priest Drury saw whether or not he was truly suffering from depression, or rather, was really undergoing a genuine spiritual crisis.

3.2 Christopher Boorse and disease as biological fact

Christopher Boorse has articulated an understanding of disease whereby disease is a value-free biological fact. Certain conditions are, by their nature, diseased states, no matter how we may think of, or relate to them, that is to say, 'disease' as such is independent of whether or not it is something to which the medical profession gives its attention, or indeed, whether it is considered by us to be a problem at all (Boorse, 1977). That the bounds to which our medical understandings ought rightly be applied can be limited in an objective manner is a fundamental requirement for Boorse, "whether or not an organism is diseased can be settled in theory by the methods of natural science" (Boorse, 1976, pg61). For such a limitation should clear up

all confusions that seem to arise between the ethical and the medical.

Boorse gives a particular structure to the conceptual landscape he is attempting to trace. He makes a distinction between 'illness' and disease'. Illness is something that is tied up with our social practices related to seeking help and medical treatment. Disease on the other hand is a scientific or biological concept that can be objectively defined independently of the social practices and values held in any particular society with regards a notion of human health. The study of disease is not therefore an investigation into what society considers to be diseased, but rather, is a science of pathology.

For Boorse the paradigm for understanding health and disease is physiology which represents the human body as being made up of numerous processes and functions. These functions are the work of goal orientated systems that can either be working well, that is, healthily, or not working well (dysfunctional), and therefore not carrying out their functions as they are supposed to. Dysfunction is what underlies disease.

Here is Boorse:

> An organism is healthy at any moment in proportion as it is not diseased; and a disease is a type of internal state of the organism which:
>
> (i) interferes with the performance of some natural function- i.e., some species-typical contribution to survival and reproduction- characteristic of the organism's age; and
>
> (ii) is not simply in the nature of the species, i.e. is either atypical of the species or, if typical, mainly due to environmental causes.(Boorse, 1976, pg61)

A disease is only thought of as illness, that is, considered something which one would seek medical attention for within our society, when,

according to Boorse, the following condition is met:

> If it is serious enough to be incapacitating, and therefore is
>
> (i) undesirable for its bearer;
>
> (ii) a title to special treatment; and
>
> (iii) a valid excuse for normally criticisable behaviour. (Boorse, 1976, pg61)

Dysfunction defines disease. Take the heart for example, this can be thought of as a sub-system which has the function of pumping blood and as long as it carries out this function it is considered to be healthy. We can, Boorse argues, easily extend the physiological picture of human health as right function to the realm of the mental by thinking of the mind as a functional system made up of sub-systems with various processes and functions. Rachel Cooper suggests, for example, a sub-system that is involved in social interactions, a disruption to this system could perhaps lead to what we would call autism (Cooper, 2007).

Organisms are said to be goal directed in that they change their behaviour appropriately to environmental changes in such a way as to produce a consistent result. Using the heart as an example, the goal of the heart is to pump blood around the body. Now, how is it that *that* is defined as its function? For certainly the heart pumps blood, but it also does lots of other things, like making a regular thud sound. Why is making this sound not its natural function? There is a hierarchy of functions within an organism at the top of which is the function or goal of survival and reproduction (Boorse, 1977). For Boorse the idea of natural function of a system is rooted in the thought that the function of a system is the contribution it makes to this over-arching goal. The function of the heart is therefore defined as the species

typical contribution it makes to the goal of survival and reproduction, namely, pumping blood around the body and supplying tissues with oxygen.

The goal directedness of these systems of the human body which can either be functioning well or not so well, as the case may be, defines function. The idea that the goal directedness of an organism is towards survival and reproduction is related to Charles Darwin's insights in his 'Origin of Species', where the thought that it is an organism's survival and reproduction that is fundamental to its nature (Darwin, 1947). Evolutionary theory, with its notion of the fundamental tendency of natural organisms towards survival and reproduction, is claimed to provide the asocial fact that pulls apart values and the fact of the matter with regards disease, that is, gives us a concrete specification of what it means to talk about the 'natural function' of the human organism, and indeed, the natural function of the human psyche.

A natural function has a further qualification. It must be the standard contribution that that system makes towards the survival and reproduction of that organism as defined against a reference class. A reference class is a natural class of organisms of uniform functional design; specifically, an age group of a sex of a species (Boorse, 1977). Here we bring in statistical normality of function. This is important for Boorse's definition of natural function. The functional systems of an organism have a function that can be defined in relation to its contribution to the organism's survival and reproduction, however, Boorse notices that if a Squirrel's tail is caught in a crack en route to being run over by a truck, it does not follow that that is a natural function of the squirrel's tail. Hence the need for the qualification of statistically normal function, it is how the system normally contributes to the survival and reproduction of the organism that is relevant to defining health and disease.

Think back to the case Drury described of the priest who was diagnosed with depression. To answer the question of whether it was

right to treat him for depression or not comes down to the question of whether or not there was a dysfunction of some natural function. What natural psychological function is involved, perhaps there is more than one, is a matter for neurological and psychological scientific investigation. For our purposes here we could postulate, very crudely, some mechanism associated with feeling good about achieving something, or some form of sadness mechanism, that has become dysfunctional, that is, is no longer contributing to the individual's survival and reproduction in a species typical manner. If this is the case, then Drury was right to treat the priest for depression.

3.3 Objections to Boorse

Boorse tells us he builds on the intuition that "what is normal is natural" such that it is how the body normally functions towards the goal of survival and reproduction that is the state of health, and it is deviation from this state that can be seen as dysfunction. 'Normal function' as biostatistical normality underpins the notion of disease. It is precisely this, difference as disease that seems to be the most problematic feature of Boorse's account. Bolton puts it succinctly when he tells us that "mere difference will not do for capturing concepts like disease or dysfunction: these concepts already have the connotations that problems are caused to the bearer, while mere difference from average/usual functioning has no such connotation" (Bolton, 2008, pg112). This objection that mere difference is not sufficient for us to define disease has a number of dimensions. I will focus on points that Cooper and Bolton bring up. I draw from Cooper a couple of counter examples which aim to show that the concept of disease is not fully captured by Boorse's account, that there are widely held examples of diseased states that do not fit into Boorse's theory. From Bolton I draw a couple of theoretical and practical difficulties that revolve around the notion of distinguishing between natural Vs cultivated/social psychological functioning.

Rachel Cooper suggests that natural dysfunction defined in relation to biostatistical normality is neither necessary nor sufficient for a definition of disease, that what Boorse describes as disease is not in and of itself enough to define disease. It is not sufficient in that difference in and of itself does not seem to capture what we mean when we talk about disease. Not only is biostatistical normality not sufficient, Cooper argues that it is not even necessary in defining disease. For it seems, Cooper argues, that our concept of disease can be applied to cases where no statistically significant difference in the population exists, and yet a diseased state can rightly be said to be present. Cooper provides some counter examples that appear quite problematic for Boorse's conception of disease to account for. The point of persuasion here is that if an account of what disease is fails to account for some basic intuitions of ours about health and disease, then the account is most likely to be flawed somehow.

Here is the first counter example. When male bees have sex they explode as their rear end remains in the female. We could hypothesise that this has something to do with increasing the chances of fertilisation, or it may just simply be how things happen. The point is that from a biological point of view, nothing has gone wrong here, there is no dysfunction, especially from a biostatistical point of view, this is how things go for male bees of certain bee species. Cooper asks us to imagine that one day a slight mutation leads to a bee being born that does not explode upon mating, but rather can go on with its life thereafter. It seems that this bee no longer functions in a statistically normal way towards its survival and reproduction. However, the well being of the bee, from our point of view at least, seems to be, if not better, at least no worse off. The point of this example is to illustrate how individual well being and biological function can fall apart, something Cooper suggests should make us suspect that Boorse's account is missing something fundamental about health and disease. There is an intuition that the notion of disease has to be tied up somehow with individual well being. Given Boorse's account of disease it appears that the two are only related circumstantially.

To add to Cooper's example, we can imagine that perhaps this mutant bee is extremely virile because of its ability to have multiple sexual encounters and so as a result, this trait is spread to a point where all bees are born with it. But occasionally, amongst this population of non-exploding bees, a bee is born that dies after having sex. Would we not be inclined to call this a genetic disease? The answer for Boorse is of course yes, for such exploding bees within this population are not functioning in a species typical manner. However, it does seem at least odd that it is only because it is now unusual amongst the population that dying after having sex is considered a disease. When it was common it was not considered a disease, and yet now it is considered a disease simply due to the fact that it is no longer normal within the population. The point Cooper wants to make with this example is that well being and natural function can radically fall apart. It is not the harm that the process of exploding after death causes to the individual that decides whether there is a disease process or not, but rather, whether or not such a process is contributing to the survival and reproduction of the species in a species typical manner.

For Cooper this example does not disprove Boorse's theory, for as I have mentioned Boorse can maintain that amongst the population of bees that do explode after death there simply is no disease. This may not exactly track our intuitions about the connection between individual harm and disease, but, Boorse would claim he is not attempting to explain or account for all our intuitions about disease. Despite this, Cooper suggests that this example should make us suspect that the notion of 'biological dysfunction' does not capture ideas like health, disease, sickness, illness and so on.

The Second example Cooper uses is slightly more pertinent to our discussion of mental disorder, and that is homosexuality. Homosexuality was removed from the *DSM* during the 1970s as a result of strong opposition from the gay rights movement (Herb, Stuart, Stuart, 2003), who argued that homosexuality should not be

seen as a mental disorder, that is, as something that needs treatment, or medical intervention, but rather as a way of living that is healthy and ought to be seen as a natural part of human life. Boorse's account of disease appears to suggest that homosexuality is indeed a disease. For a subsystem of the human organism to be diseased is for it to fail to fulfil its biological function in a species typical manner, that is, to contribute in a statistically normal manner to the survival and reproduction of the individual organism. Now, it can be disputed whether homosexuality is indeed a biological dysfunction, but it seems fairly persuasive to suggest that there is some kind of biological mechanism that attracts members of the opposite sex to one another in order to promote reproduction, and that in homosexuals this is dysfunctional and is therefore a diseased state. This may not be the case, it may be possible that homosexuality is biologically advantageous in terms of survival and reproduction. However, it is because it is *conceivable* here that homosexuality is a disease according to Boorse that Cooper suggests his account does not seem to be able to capture something crucial about health, disease and related concepts. For whether or not homosexuality confers an adaptive advantage in terms of survival and reproduction appears to be irrelevant when it comes to whether or not we should consider it to be a medical condition.

This does not necessarily refute Boorse. Boorse can answer both of Cooper's objections here by maintaining his distinction between disease and illness. It may well be the case that individual well being and biological function and dysfunction do not completely overlap, but for Boorse that is beside the point. What he is trying to characterise is a value free biological fact. There is no value judgement implied in the notion of dysfunction, bad or good, it is simply a fact that homosexuality is a breakdown of a system that contributes to reproduction, nothing more. Whether or not that is treated as an illness, as something that is seen as in need of medical attention and is bound up with social practices of help seeking and treatment is something else altogether. Boorse's theory is not

concerned with mapping that part of the story. The question is, 'is there a dysfunction?', if so, there is a disease, in which case it is potentially something that could be considered by society to be an illness, that is, something to which the medical profession can help with. Regarding exploding bees, there is no dysfunction, and therefore no disease, and nothing that ought rightly to be called an illness. Homosexuality is a disease, but, this does not mean we ought to think of it as an illness.

Cooper's argument is that although Boorse's account makes sense, it is not conceptually incoherent or logically flawed, it nevertheless fails to capture what it means when we talk about disease. Boorse's response to this would be that we often talk of disease and illness in a confused manner. Our every day intuitions may not agree completely with his account, but neither do our intuitions about Galileo's hypothesis that it is the Earth that goes moves around the Sun, not the Sun around the Earth. Here, we have run into one of the fundamental difficulties of this project. By what standard do we judge an account of mental disorder (or disease in general) as being correct? Surely not simply by how well it coheres with our everyday intuitions about health, for are these theories in part not supposed to put our confused thinking in the light of the truth? This is a problem that will come up again later. But briefly what has happened here is that Cooper has argued that Boorse's account fails to account for some basic intuitions about health and disease, to which Boorse could reply by simply denying the validity of those intuitions. Homosexuality is a disease, albeit one we choose not to treat. Presenting counter examples to a theory of disease can easily be lead down this track, I therefore will now look at Bolton's objection to Boorse which attacks the conceptual coherence of Boorse's conception of natural function directly.

Bolton critiques Boorse's reliance on the notion of species typical functioning. Two conceptual difficulties that Bolton raises (Bolton, 2008) are first of all to do with that of defining what is statistically normal when it comes to psychological traits, and secondly the

problem of to what reference group is normality defined. Firstly, for psychological and behavioural traits there seems to be a problem with arbitrariness in what is defined as normal and not normal and therefore diseased because such traits are normally distributed throughout the population. Statistically such traits often fall on a bell curve, where the pressing question arises, at what point is deviance from the mean to be considered diseased? Any point seems somehow arbitrary. We can put the cut off point where catastrophic failure of the system leads to severe harm, but this is to bring in a notion of harm, and therefore values, and it is precisely this that Boorse wants to avoid in his conceptualisation of disease, it is statistical considerations about normality of functioning alone that should determine a diseased state.

The second problem of appealing to a reference group, Bolton suggests, is that it is unclear what a species wide sample to determine normality would look like, and in practice seems rather difficult to come up with. Basically, it is not at all clear or simple to utilise the notion of species wide psychological or physical functioning. To resort to local reference groups seems problematic. Bolton asks us to consider depression in relation to whether such a condition is a disease when compared to a reference group where the genetic predisposition is common, and adverse life events and circumstances are also prevalent such that depression is fairly common. We want to ask, is it still a disease? It is if we used a different reference group with protective factors, and a low genetic predisposition such that depression is relatively uncommon. However, Bolton asks us, by what group mean is the gold standard to be set? A species wide mean appears practically unachievable, whilst a local reference group is problematic. It seems, Bolton suspects, that such a gold standard could only be set by our intuitions and common practices in relation to what health is and what constitutes living well. This is chiefly a practical problem of implementing Boorse's theory, rather than a theoretical one.

Boorse could concede that a 'normal' reference class member is to a certain extent 'ideal' in that it does not completely mirror the statistical norm for the species. However, this is still problematic. Bolton identifies a potential risk here. In forming a reference group by which to define what counts as species-typical normal functioning there is the possibility that "we would have in mind the dominant social group in any given society, likely to be relatively better resourced". Another possibility along a similar line is that we end up with an idealised level of functioning, one that "would presumably be a function of such as a good diet and good resources and not too much stress, and by this move the disadvantaged have not only poor diet and low resources and high levels of stress, but are also regarded as having subnormal function (and disease and disorder if the outcome is harmful)". Bolton argues that there are facts of nature involved in all of this, but there is no absolute level of normal functioning that can define what is subnormal. In an ironic twist, Bolton goes onto claim that "the misplaced assumption that there is an objective, statistical notion of dysfunction runs the risk of ending up in practice with an idealised notion of normality, likely to coincide with the functioning of the well-resourced, reflecting after all features of social organisation rather than fact of nature"(Bolton, 2008, pg114). Mere difference does not appear to capture our concept of disease, there seems to be a danger where we equate the two in that we may actually be doing just what the anti-psychiatry movement of the 60s and 70s taught us not to do, namely equate mere difference with disease, or indeed, mistake a social/ethical problem for a medical one.

George Canguilhem argues towards a similar conclusion. A Statistical anomaly does not in and of itself suggest to the scientist a pathology. Canguilhem develops a radically different account of the pathological from Boorse. I want to introduce it here to give an idea of the scope for alternative approaches to this topic. He argues that there first of all must be the phenomenological experience of a pathology. The experience or sensation of ‘obstacle, discomfort, or harmfulness’. For Canguilhem, pathology begins here, from an individual's experience.

Something is not going well. Of course this is not enough to characterise pathology- I may feel odd, but it may be psychosomatic, or indeed, on the other hand, I may have cancer and be quite unaware of it. However, we call cancer a disease because of historical pathological investigations that began from *obstacles, discomfort and harmfulness in particular individuals*. It is from such experiences that we initially begin an investigation that looks to define and heal. Often what is found is some form of anomaly. The important suggestion for us here is the thought that pathology does not simply begin with the recognition of a statistical protuberance. "Statistical divergence such as simple varieties are not what one thinks of when one speaks of anomalies; instead one thinks of harmful deformities or those incompatible with life, as one refers to the living form or behaviour of the living being not as a statistical fact but as a normative type of life" (Canguilhem, 1966, pg136).

Interestingly, Canguilhem takes normativity to be both, what is normally done around here, the norm, but in addition to this, normativity is the power to establish norms. "Diseases are new ways of life". Life is not only a set of norms, this is how things go, but is also something that brings about new forms of life, new ways of living, new functions, new modes of health. "The patient is sick because he can admit of only one norm... the sick man is not abnormal because of the absence of a norm but because of his incapacity to be normative" (Canguilhem, 1966, pg186). Under this interpretation, the notion of statistically normal functioning fails to capture fully the concepts of disease and health.

Bolton writes that research in epidemiology and genetics have shown that many of the conditions that psychiatrists treat are common variations of traits held throughout the population, for example, around twenty-five percent of people suffer a major depressive episode at some stage in their lives, with this number being higher in stressful environments. Some models of autism suppose that it represents extremes of general population traits. What findings like

the above on normal variation do is they "broaden our view as to human nature, chipping away at the idealisation of normal function and the attribution of abnormality and disorder". Adding to this picture, Bolton draws a moral that "To the extent that an idealisation of normal functioning has driven attribution of disorder, there is now disquiet about the attribution. Or to put the point another way, the more we learn about the diversity of human nature and the human condition(s), the more problematic the notion of disorder becomes" (Bolton, 2008, pg115-16).

Boorse disputes this, arguing that,

> One should not underestimate the mileage that can be got out of elementary functional assumptions that are scarcely controversial. We may surely assume, for example, that the main function of perceptual and intellectual processes is to give us knowledge of the world. The imperfection of the cognitive apparatus is obvious. Since there are both limits to human intelligence and to the evidence on which it works, it would be wrong to suppose that every false belief is a functional abnormality. Nevertheless, one could plausibly suggest that the perceptions and beliefs of a healthy mind must at least show, in Jahoda's words, "relative freedom from need distortion' (Jahoda, 1958, pg51). That is, if my cognitive functions are disrupted to a highly unusual degree by my wishes, it seems safe to call my condition an unnatural dysfunction, i.e. a disease. By this standard schizophrenia and all other psychoses with thought disorders look objectively unhealthy...These arguments show that some elementary functional claims about the species, together with a small body of widely accepted descriptive information about the mental processes of psychotics and neurotics, may give good ground for calling these conditions pathological (Boorse, 1976, pg80).

The problem here is that it is all too easy to mistake our own customs,

and what we consider to be reasonable to believe for what is simply the natural and the right way to think and reason. What is to count as having one's cognitive functions disrupted to a highly unusual degree by my wishes? Could this not end up simply reflecting the norms of belief around here? That is, what, within this community, is reasonable/understandable to believe. Employing Boorse's theory, it is when the functions of our psychological faculties related to knowledge and reasoning are operating in such a manner so as to fail to contribute to the survival and reproduction of the individual concerned in a species typical manner.

However, how obvious are these elementary functional assumptions? What I want to suggest is that, echoing Drury, we risk forgetting how our own manner of life can inform judgements of what counts as a normal and healthy psyche to such a deep level that it may be impossible to make the necessary distinction required for talk of natural human psychological functions. Is my belief that Christ came to me last night and told me to give away all my worldly possessions and to go on a pilgrimage to a holy place a delusion, are my thoughts and beliefs being distorted to a highly unusual degree by my wishes? That is, are they relatively free from need distortion? Are my intellectual and perceptual processes functioning to give me 'knowledge of the world'? Perhaps the associated mental processes are indeed distorted to a highly unusual degree meaning I have a disease of the mind. Again, how do we define 'distorted to an unusual degree'?

Consider the following: perhaps my wish is to escape from the excess I have witnessed amongst my friends. A wish that may be related to my desire to live my life as my parents would have been proud of- perhaps both were quite devout Christians who instilled in me as a young man a strong ethic revolving around good Christian values. Someone who has little understanding of, or sympathy with, Christian beliefs may indeed see this as my beliefs being distorted to a highly unusual degree by my wishes, and hence delusional. However, within a Christian community such a belief may make perfect sense. It

appears that having ones cognitive functions disrupted to an highly unusual degree by ones wishes rests in large part upon social context.

When is it, for example, the case that the psychological mechanisms associated with sadness are functioning in a manner that ultimately promotes survival and reproduction in a species typical manner, and when is it not? Was Queen Victoria's period of mourning excessively long and therefore pathological, or was it perhaps noble in the sense it showed how deep her loss was? Could such a question really be answered by appealing to 'elementary functional assumptions'? Or would it, as Drury claims it must, be answered with reference to our own manner of life, our own values, ideals, social norms and so forth. Indeed, can we even begin to characterise a natural function associated with sadness? And of course, what if an individual's psychological mechanisms related to sadness do promote survival and reproduction but in a manner that is atypical? This would not be health as such, much in the same way that a squirrel's tail getting caught and stopping it from getting run over by traffic, is not something that comes into consideration when considering the health of the animal.

This example of the squirrel can be stretched to make a point that chimes with Canguilhem's assertion that 'diseases are new forms of life'. Let us imagine that this Squirrel lives by a busy road, and that each time it goes to run blindly onto the road its tail gets caught in a fence that this road has consistently running along either side of it for its entire length. Each time the squirrel's tail gets caught the squirrel is forced to a stop allowing it to assess the traffic and cross safely. This happens consistently, and were it not for the squirrel's unusually shaped tail, if it were to have it damaged for example, it would the next time it came to the road simply run straight onto it and quite possibly get run over. If not the first time, this would happen soon enough. For *this* squirrel having the particular shaped tail it has does promote its fitness in terms of survival and reproduction. However, this tail may not be as effective at allowing this squirrel to do what squirrels normally do with their tails to promote survival and

reproduction. However, overall, it is promoting its chances of survival and reproduction considerably. It could though be potentially seen as a disease for Boorse, in that its tail fails to carry out its function in a manner as defined by its species. Canguilhem, on the other hand, would see here a new form of healthy life- albeit a slightly far fetched example, one which nevertheless has the core of Darwin's theory in it. For could not squirrels with such tails thrive in an environment crisscrossed with roads?

Here we see the radical difference between Boorse's account of health and disease and Canguilhem's account. For Boorse, what is normal is healthy, and it is deviation from this norm that is the basis of disease, whereas, for Canguilhem, health can be atypical or abnormal, what counts is the success of these new forms, functions, processes, of promoting life (however, and whatever, that may be). Boorse's theory appears to suggest that deviation from the normal can constitute disease, even when such deviation is actually beneficial to the individual concerned, as in the case of the squirrel with the unusual tail. The equation of difference with disease appears to be quite inadequate for defining what ought to count as conditions that are potentially within the purview of the medical profession.

3.4 Wakefield: disorder as harmful dysfunction

Wakefield too attempts to offer a naturalistic grounding of psychiatry in the notion of natural human function. Wakefield uses the concept disorder to denote such problems, and the idea of function and dysfunction as the naturalistic matter of fact that underpins disorder. The breakdown of a natural function, as with Boorse, is what goes wrong in cases of mental disorder. Wakefield believes that a general theory of disorder can be formulated such that it will be able to give us a guiding principle on which to base our psychiatry. In Wakefield's words, "the requirement that a disorder must involve a dysfunction places severe constraints on which negative conditions can be

considered disorders and thus protects against arbitrary labelling of socially disvalued conditions as disorders" (Wakefield, 1992a, pg386).

Disorder for Wakefield is seen as being underpinned by two conditions, the first is that a natural function must be in some sense malfunctioning, that is, there is a dysfunction, and the second is that there must be some kind of harm involved because of such a dysfunction. Our concept of sickness/illness/disorder, that is, what is considered to be within the scope of medical representations, has both a fact, and a judgement of value relating to that fact. There are two parts to his analysis, one is factual, objective, scientific, this is dysfunction, which can be defined in non-evaluative terms, it is independent of the social world, the other is a value judgement of harm that overlays that fact of dysfunction. This roughly parallels Boorse's distinction between disease and illness, where the former is conceived of as purely descriptive and value free, while the latter is tied up with the medical profession, help seeking and what we actually think of as illnesses or medical conditions. The important part in both analyses is this notion of a biological dysfunction that is present in all true medical conditions. For Wakefield, harmful dysfunction, where such a biological dysfunction causes obstacle, discomfort, or harmfulness, is what defines illness and disease. If there is a 'harmful dysfunction' then the medical response is appropriate.

Where Boorse grounded such a conception in the statistically normal contribution a system made to the survival and reproduction of an organism with reference to a particular group or class (i.e. a species), Wakefield relates function directly to evolutionary theory. Evolution has shaped life such that it has formed organisms with defined forms. A bird has wings for flying, eyes for seeing, beaks for eating, and not just eating in general, a bird's beak is suited to a particular form of eating. It is upon this intuitive picture of function that Wakefield builds.

A function for Wakefield is an internal mechanism that has been

'designed' by nature to perform a particular task. The existence of a functional system is said to be explained by the effect that system has. Beginning more broadly, the function of an artefact such as a car can be explained by the effect it has, such as the power of rapid transportation of heavy loads- we build cars for that purpose. This counts as an adequate explanation of its form and function and why such things exist. A car has broken down and therefore needs mechanical attention when something occurs that impedes its function. Wakefield takes this notion of function and applies it to living organism whereby function is couched in terms of the effect a particular mechanism or structure has. For example, the effect of the heart is to pump blood around the body, it is this effect that explains why we have hearts. "The concept of natural function can be analysed as follows: A natural function of an organism or mechanism is an effect of the organ or mechanism that enters into an adequate explanation of the existence, structure, or activity of the organ or mechanism" (Wakefield, 1992a, pg382).

With a car, why it has the particular function it has can be explained by the presence of a designer, it is for *this* purpose that it was designed. However, with the heart, we have not yet fully accounted for the thought that it is its effect that explains its function. Evolutionary theory fills the gap. It is how the effect contributes to the inclusive fitness of the species concerned that takes the place of the intentional designer. The natural function of the heart can be explained in that it does what it does because doing so increases the inclusive fitness or chances of survival and reproduction of the organism in question. The thought here is that evolutionary theory can explain why certain structures and systems within an organism are the way they are and why they do what they do. This can be determined by thinking about how such a mechanism/system increased the chances of survival and reproduction of previous generations, meaning that the natural function of a mechanism is set by its evolutionary past.

The beating of the heart is fairly obvious, intuitive even, but as

Wakefield points out, finding out what the natural function of mental mechanisms may prove to be "extraordinarily difficult". This is one of the chief difficulties with Wakefield's account, what sense are we to make of 'natural psychological mechanisms'. The overall spirit of my concern follows Bolton when he argues that the distinction between the social and the natural has broken down in the recent paradigm of cognitive psychology, making the notion of a naturally defined psychological function as opposed to socially defined functions problematic. Secondly, a problem arises in practice as to how we are going to put this theory into practice and apply its findings to the clinic.

3.5 Counter examples: dysfunction is not necessary for disorder

As we saw with the section on Boorse a counter example is a case that while not suggested as such by the theory being put forward is nevertheless widely considered to be a legitimate form of mental disorder. Either the counter example is in reality not a genuine disorder, or, it is, in which case the theory has failed to successfully delineate the field of psychiatry. Telling where the truth lies, as I have already mentioned, between these two options is difficult to assess.

Wakefield's analysis rests on a strong intuition, namely that of the thought that with mental disorder something has gone wrong *with the individual*, something is not functioning as it ought to (Bolton, 2008). It is in this that Derek Bolton sees the strength of Wakefield's analysis, and its apparent resistance to counter examples. An objection that is often raised to Wakefield's suggestion on how we ought to think about disorder in relation to health is to come up with counter examples (Cooper, 2007) (Lilienfield, Marino, 1995) (Hinshaw, Richters, 1999).

Cooper argues that there may very well be a genetic basis to disorders which may confer, or may have conferred in the past, some kind of

biological advantage. Cases where we can all agree that there is a disorder, that there is a problem here to which the medical response is appropriate and yet there is no dysfunction, there is no mechanism or system that is not operating in a way that is contrary to how evolution has 'designed' it to function (Cooper 2007). One way to put this is that the pressures of the pre-historic world are not coextensive with that of the social world of today. Cooper lists a number of possible counter examples, including bipolar disorder, sociopathy, obsessive compulsivity and anxiety disorders that do not fit with Wakefield's theory.

Agoraphobia is characterised by repeated attacks of intense fear and anxiety when in situations where escape may be difficult ("I can't get out of here!"), and where help might not be readily available. Imagine a state where one is incredibly cautious of dangerous situations, where the danger may be life threatening: imagine life on the African savannah before history began. It does not seem to be unreasonable to suggest that such an overcautious disposition may be advantageous in terms of survival and reproduction. Such a disposition may not be very pleasant for the individual concerned, they live with fear, whereas someone without such a disposition may not have such an uncomfortable sense of the world, but may perhaps because of this have been much more likely to come to grief. Their inclusive fitness, or chances of a long and reproductive life may have been curtailed because of this. Such over cautiousness may become something that prevents one from living well in a world where such dangers are not present, or at least not as *real*, that is, in terms of the potential for death or serious physical injuries. A system, or psychological mechanism that was 'designed' for that purpose may be severely debilitating in a different environment. Of course such lines of thought are highly speculative, but the point for us here is that it is *conceivable* that such a mismatch between what our psychological mechanisms were designed to cope with and the present environment they are presented with could lead to serious problems is enough to suggest that biological dysfunction, as Wakefield defines it, is not

necessary for psychiatric conditions.

Underlying this critique of Wakefield's position is the possibility that there is a mismatch between biological function and the current environment in which an organism finds itself such that, although a mechanism or system X is functioning as it was designed to function, in the current environment such a function is harmful to the individual concerned. Schizophrenia, it has been noted, has cross culturally stable incidence rates higher than one would expect if it were simply the result of the chance effect of mutations, suggesting that it may have conferred some form of adaptive advantage in the past. A strong link has been demonstrated between genetics and Schizophrenia through twin adoption studies (Lewis, Leiberman 2000). The prevalence of 'core schizophrenia' is roughly 1% of the human population (Brüne, 2003). The interesting fact here, and what Martin Brüne calls the 'enigma of schizophrenia' is that it seems to reduce the fecundity of people with the condition by about 50%, and yet natural selection has allowed the genes associated with schizophrenia to persist in the human population. An enigma that suggests that these genes somehow convey an adaptive advantage in terms of survival or reproduction and that the genes linked to schizophrenia may be linked to other genes that convey an adaptive advantage. The possibility here is that, although this was the case in the past, at present, these genes seem to be linked with a condition that can be quite debilitating.

There have been a number of theories hypothesised to suggest why this may be the case. It has been suggested that there may be an advantage conferred in terms of resistance to toxins or infectious diseases. Another is that an advantage may have existed in the social domain for example, increased creativity of 'schizotypal Shamans' in certain social settings. Given a different social environment, the genes associated with Schizophrenia can confer an advantage, or at least not reduce ones fecundity. Brüne also looks at a theory by T. J. Crow (Crow, 1997) that hypothesises a connection between the genes linked to schizophrenia and the development of language. According to this

line of thought, Schizophrenia represents the extreme of a continuum of a functional mechanism linked to language. The details of such hypotheses are not important for our purposes here, indeed a number of assumptions that seem to stimulate the enigma have been questioned (Adriaens, 2008). However, details aside, there is the possibility that something we call an illness (schizophrenia) may be something that, in Wakefield's sense, is not a biological dysfunction as such.

Another counter-example that has been presented is the phenomena of exaptations (Lilienfeld & Marino,1995). These are functions/features of an organism that have not been directly selected for and shaped by evolutionary pressures, that have not been selected for to perform a particular function, but rather exist as the by-product of something else. What we have here is potentially a system that has a function, but has never been directly selected for according to the rigours of natural selection to perform a particular function. It is only subsequently that they have taken on a function. A case has been made to suggest that feathers initially evolved to aid in heat insulation, and have only subsequently become utilised in flight. Of course feathers have subsequently been selected for to aid in flight and that has become their biological function. What Lilienfeld and Marino think Wakefield's harmful dysfunction analysis can not explain however are exaptations where the current function was never selected for, or designed to do X, by evolution. These functions are also known as spandrels.

Acalculia, Lilienfeld and Marino argue, would probably not be considered to fall within the boundaries of disorder according to Wakefield's analysis. Acalculia involves the impairment of ability relating to arithmetic calculation. Another similar spandrel is amusia, a condition where there is an impairment in musical ability. What we have here are functions which were, so the argument goes, never directly subjected to natural selection, and hence are not strictly biological functions in Wakefield's sense. There is no biological

function that can become dysfunctional for there is no normative force (natural selection) to say what the function ought to be, and hence there is no disorder. The ability to carry out arithmetic is not something that is the direct result of evolutionary design and so when someone has a disorder relating to this, it seems to present a challenge to Wakefield's general analysis of disorder. For strictly speaking the capacities that are disordered in such cases are irrelevant to fitness (they are not capacities or functions that evolution has designed).

In response to the accusation that his account of disorder cannot make sense of exaptions, disorders that are neurologically based dysfunction of cultural capacities (spandrels) Wakefield argues that "the HDA (harmful dysfunction analysis) requires only that harm result from failure of a natural function, not that it [the harm itself] be such a failure" (Wakefield, 1999, pg466). The harm itself (impairment of mathematical ability) need not be a harmful dysfunction with Wakefield's analysis. Rather, such harm need only be the result of some natural function that has become dysfunctional. For example, with acalculia, a system upon which our ability to do arithmetic *depends* may be dysfunctional leading to problems with arithmetic. The idea is that there are certain psychological systems that have been selected for by evolution that are the basis of our capacity to carry out functions that are not in themselves biological functions. Put another way, Wakefield can say that a spandrel is dysfunctional by relating such dysfunctions back to a breakdown in the natural functions upon which they depend. Whether this is actually the case with acalculia for example is up for debate, but Wakefield's response here is conceptually quite plausible.

Wakefield can drive home a moral point too with his response to the spandrel objection. When someone fails to come to grips with the skill of reading, a spandrel, there could be two possible reasons for this. They may have simply not learned how to read or may have been taught poorly, or they may be incapable of reading because of their biology, a 'natural function' that is a prerequisite for learning how to

read may be faulty. The first two may be the result of social conditions, perhaps schools are not being properly funded, poor teaching may be a cause. With the latter there seems to be something unwell with the individual (rather than, for example, the result of poor schooling). It is precisely here that Wakefield sees his analysis as telling us something important, for we do not want to call all inability to read a disorder. "The name *reading disorder* misleadingly suggests that inability to read up to grade level is a disorder in itself (it is a serious invalidity in DSM-IV criteria that they allow diagnosis on such grounds)" (Wakefield, 1999, pg466).

This seems to be a pertinent point and what is the strength of Wakefield's analysis, for we do not want to say that all problems with reading are the result of a reading disorder, or all sadness depression. The success of Wakefield's analysis, Bolton identifies as lying within "the fact that it tracks the fundamental idea that in mental disorder something in the individual is not functioning as it should" (Bolton, 2008, pg123), something that is almost tautological in its conceptualisation. The problem for our counter examples is that we are forced to say that there is a disorder, but that there is nothing actually going wrong inside the person which seems to be open to the charge from Wakefield that we are being over inclusive in our analysis of disorder. Simply misbehaving should not be sufficient for diagnosing someone with conduct disorder, for in doing so we may be including people where their conduct could be improved by changing the social conditions in which they live. Perhaps they have abusive parents, the particular cause isn't important for us here, but simply to note, that Wakefield's analysis wants to stop us from making precisely this mistake, that is, ignoring the social world that may be generating the, in this case, poor behaviour, in our mistaken attribution of a genuine disorder where there is something actually wrong with the individual in question.

3.6 Social Vs biological function: can a distinction be made?

"Social norms interfere with biological laws so that the human individual is the product of a union subject to all kinds of customary and matrimonial legislative prescriptions".
-George Canguilhem, *The Normal and the Pathological, pg 136*

Derek Bolton believes that Wakefield's analysis stands up pretty well to the 'frontal attack' of counter examples. Wakefield's approach can not be directly refuted on its own terms, I therefore in the following offer a critique of a number of background understandings and assumptions Wakefield's theory relies upon. Firstly, I propose to question the assumption that a distinction can be made between psychological functioning that is innate, has evolved naturally, and functioning that is social, or cultivated. Secondly, I claim that in practice the harmful dysfunction analysis of disorder cannot make a principled distinction between pathology and normality without drawing on various social standards. And thirdly, in an objection that runs along the lines of suggesting that even if we admit that Wakefield's analysis does demarcate genuine mental disorders, it does not follow that only 'genuine mental disorders' ought to be treated by the medical health profession. This is to allow for the possibility of harmful psychological conditions that are not strictly 'disorders' in Wakefield's sense, but are such that the kind of things mental health professionals do may be of help. This involves accepting the notion of a psychiatric conditions that are socially defined, that is, cultivated dispositions, habits, character and so on, that are harmful to the individual concerned.

Wakefield's analysis rests on an assumption that there is a strict distinction between psychological functioning that is innate (evolved/natural) as opposed to social (cultivated). Indeed, this is the substantial spirit of Wakefield's analysis. Namely that it is precisely natural functions and their aberration that ought to be the purview of

psychiatry and the mental health profession in general, rather than the functions that are a result of various social forces, the cultivated self. We see here the notion that with mental health problems, the problem is to be seen as resting *within* the individual concerned, as opposed to the environment in which they live. However, such a distinction is quite difficult to maintain.

The two are intertwined to such a degree that there are very few 'purely biological' psychological functions and that there are very few (or indeed no?) purely social/cultivated psychological functions. Some psychological faculties or functions are more highly cultivated, are more relative to the social milieu than others, but all are relative to our biological nature, the kind of natural creatures we are. On the other hand, our natural biological faculties are shaped and formed by the social world such that we cannot define the function of such faculties devoid of a social context. We can think of a continuum, with at one end our natural capacities that are less informed by the social world, such as the beating of the heart, or the gag reflex, while at the other end, we have functions that are heavily informed by the social world. Examples of which might include our faculties associated with depression. When does sadness become depression? Something that is informed by being cultivated into a group of people with a common understanding of how things work around here and what is considered appropriate behaviour.

It is problematic to make a distinction between natural psychological functions and cultivated ones. First of all, human evolution has taken place within social groups, in which case some evolved functions are social, therefore breaking down the distinction between the social and the natural. Within societies existing before history began, it is not too presumptuous to assume that there would have been an ideology and a notion of the good life, a mirror world that had a looping effect (to borrow Ian Hacking's term) back on our biological natures. The values held by individuals in earlier societies (and in general the nature of the social world in which they lived), has played a role in shaping the

biological nature of people today. It is not as though throughout evolutionary history humans lived as isolated individuals without any form of social existence in which our psychological capacities evolved to carry out discrete functions and that it is on top of this that all our social adeptness has recently arisen. Rather we evolved in social settings in which psychological capacities that favoured such living were advantageous and were hence propagated and refined. Once we acknowledge this, it seems difficult to define psychological functions without reference to social life and what good social life consists in.

The notion of natural psychological function rests upon the idea of the 'modular mind'. The mind is thought of as being made up of numerous computational elements that carry out particular, definite and discrete tasks. "Far from being an all purpose cognitive device, the human mind is assumed to be constituted by numerous separate but interconnected "modules", assigned to different information-processing tasks" (Varga, 2011, pg42). This understanding of the mind is essential to Wakefield's project in that there have to be particular functional systems with discrete and definite goals against which dysfunction can be defined: modules for such things as grammar induction, to facial recognition of emotions, to mechanisms that detect things such as cheating, eye direction and animacy (Varga, 2011).

However, our nature, our genetics, contrary to a modular conception of the mind, does not (at least necessarily) give any specific, or definite functions with regards to many of the psychological functions and faculties we possess. Rather, while evolved factors may give some level of content, such content is diversified in numerous ways by the environment, especially the cultural and social world into which one is socialised. As a result there is no such thing as a 'psychological function', or mental capacity isolated from our engagement with the world, both material and social. Put another way, although our genetics give us certain mental dispositions, it is only through engagement with the world that such dispositions attain specific content. The mind is not simply determined by genetic factors to carry

out particular discrete functions, functions that we can determine by thinking about our evolutionary past, "ah, *that* is what being sad is meant to be all about", but rather as something that is much more open ended, intricate, and malleable.

Hinshaw and Richters make a similar point. They claim that because of the experience based modifiability of the more recently evolved higher brain functions, those connected with cognitive, social, emotional, and personality functioning, our evolutionary past is insufficient when it comes to conceptualising their functions or dysfunctions (Hinshaw, Richters, 1999). The higher level brain systems, they argue, do not contribute to adaptive fitness by successfully carrying out and maintaining fixed task specific functions, such that we could easily identify when one of these brain systems is not doing what it was designed to do. Rather, these brain systems, or what we might call, psychological capacities, are much more open ended, and come about through the interaction between the organics of an individual and the material and social world to which they are to adapt. Hinshaw and Richters conceptualise the functions of our brain or psyche as more of a general policy statement, rather than a to-do list, running something along the lines of "to interact with the environment in ways that maximise the body's chances of survival and inclusive fitness" (Hinshaw, Richters, 1999, pg440), a thought they draw from John C. Eccles' *Evolution of the Brain: Creation of the Self* (Eccles, 1989).

There is an indeterminacy, or underdetermination here in talking about functions of psychological mechanisms or of the brain. Not only is it difficult to specify what the natural function of a psychological capacity is in evolutionary terms, but in addition to this, there may be no single correct answer, and depending on how we describe the function, we change what counts as a disorder or not. This can be seen in an example that Hinshaw and Richters use as a counter example to Wakefield. Something interesting comes out here, where by redescribing the 'function', what this mechanism is *for*, Wakefield is

able turn a problem for his theory into something that fits it quite well. Although Hinshaw and Richters give this scenario as a counter example to Wakefield's theory, that is not my purpose here- as already stated, I agree with Bolton's view that Wakefield's theory is ultimately resistant to direct refutation. My aim here rather is to make a point about the concept of the modular mind and the difficulties encountered, both epistemological and conceptual, when trying to specify exactly what it is a particular module of the psyche has been designed by evolution to do.

Imagine a child that grows up in an aggressive and abusive family that leads to enduring changes in their nervous system and personality development such that they acquire a 'hostile world' orientation, involving heightened vigilance, a lowered threshold of anxiety arousal, wariness of other's intentions, emotional distancing strategies and aggressive tendencies (Hinshaw, Richters, 1999). The 'function' of the psychological mechanism here is to adapt the child to living successfully in the world, success in evolutionary terms being how well one physically survives and reproduces. In a hostile world perhaps such an upbringing would be beneficial in that sense, however, what if such a child, after growing up in such a family, goes on to enter a world that is normal (is civil, decent*)*, nurturing, and relatively non-threatening, at least not in an immediate physical sense. The skills developed to cope with the aggressive and abusive family world are no longer needed. Indeed, such skills (if we can call them that, dispositions or personality could also do here) may be a major limitation on living a good life. Hinshaw and Richters argue that, although nothing evolutionary speaking has gone wrong, there is no dysfunction, the psychological mechanisms involved here successfully adapt the child to the environment in which it is born, for *that* is its function. Nevertheless, an individual brought up in such circumstances who subsequently goes on to find themselves in a relatively non-violent world may suffer from significant impairment in social, emotional, and psychological functioning.

The child develops psychological dispositions that are potentially quite damaging, that is they have a non-dysfunctional disorder. Wakefield has a response to this critique which is conceptually quite satisfactory, however, it shows how slippery the terrain is when we try and talk about 'natural human psychological functioning'. Wakefield puts forward two ways of understanding what is going on here in light of his theory. Firstly, if the psychological mechanisms involved are responding to an environment that they were designed to respond to, that is, if family conditions are within the normal range of environments to which such mechanisms evolved to respond to, then the result ought to be seen as normal variation in personality types, there is no dysfunction here, no disorder, and therefore it is not something that ought to be responded to using medical representations and understandings. Rather political and ethical or moral considerations ought to be brought to bear on any perceived problem. The problem ought not to be located within the individual, there is nothing wrong with them as such- evolutionary speaking this is just how human beings respond to such situations. The child may develop a personality type that is not very nice, in fact, the individual may suffer as a consequence, but, what we categorically do not have here, according to Wakefield, is a medical condition. We might look to the social conditions that lead to such a personality type, or we might give the individual a good book to read, or may simply talk to them, to help them cultivate a self that is more conducive to the social milieu in which they find themselves. We ought not however to think in medical terms here, to do so would be to blind ourselves to what is really going on and what really will help. This is a social problem, echoing Szasz, rather than a medical one.

The second way Wakefield deflects this counter example is by redescribing the nature of the relevant psychological function or mechanism. Wakefield suggests we can think of this case as where the function of the psychological mechanisms involved is to shape an individual's personality so as to allow them to function well not just in the narrow environment of their early years, but also in the

environment in which they live later on, that is, the wider world. Here is Wakefield, "if the mechanism's function is to shape personality specifically in response to the early broader environment (not to the family environment, which evolutionarily is expected to be reasonably benign) to prepare for the later broader environment, then the "accidental" setting of personality parameter by extreme (evolutionarily unexpectable) family abuse is a dysfunction. By responding to family abuse rather than the broader environment, the mechanism fails to perform its function, explaining the tendency to attribute disorder" (Wakefield, 1999, pg468).

If we do think of the relevant psychological function here in *this* manner then it is indeed the case that we have a true mental disorder. However, the problem is, which of the two is the right way to characterise the natural function involved? There are two possible ways of describing the natural function. The first which Hinshaw and Richters use to mount a counter example to Wakefield is characterised as the function that adapts the child appropriately to the world- which involves learning and adapting to ones immediate surroundings as a child. These immediate surrounding are more often than not one's immediate family- especially in a context where there is a well established norm of the 'nuclear' family. Allowing room for the thought of a non-dysfunctional disorder in the form of bad/damaging dispositions or characteristics and habits learnt during childhood. Wakefield however suggests that the relevant function could be thought of in a different manner where the purpose of it is to adapt the individual not just to the narrow environment of someone's earlier years but to the broader environment and wider world into which they will later enter. Although Wakefield has successfully defended his position against the counter example, he has inadvertently revealed how slippery the notion of 'natural function' can be.

There seems to be a great indeterminacy or even underdetermination, when it comes to specifying exactly what the natural function of our psychological capacities are. The claim here is that not only is it

difficult when we look back over our evolutionary history, which tends to involve a lot of highly speculative theorising, to work out what a psychological capacity of ours did that increased the inclusive fitness of those that possessed it in the distant past, but in addition to this, there may be actually no way of coming up with a single answer. We can describe the natural functions of the human psyche in a number of different ways. The facts, or the evidence, we have available to us is insufficient for us to identify what, with any level of detail or specificity, a biological function of our psychological capacities may be. This is not to deny that there is not room for potentially quite telling and accurate explanations of our psychological dispositions related to evolutionary theory, for example, our behaviour in relation to sex, it is rather, simply *to deny that such explanations can set specifically enough the parameters of the normal against which the pathological can be defined.*

What I have dealt with so far are conceptual or theoretical problems with the notion of 'natural function'. I want to now look at how in practice Wakefield's theory would be employed to demarcate disorder. Employing Wakefield's theory our investigation into whether such and such a condition should count as a disorder will involve highly speculative and quite involved theories employing evolutionary psychology and genetics. Derek Bolton argues that such an approach, that rests upon such a basis may be very difficult to implement in a clinical setting. This is a practical or epistemological issue. Interestingly, what Derek Bolton asks is how does Wakefield himself make a distinction between function and dysfunction, order and disorder? In answer to this Bolton suggests that Wakefield pretty much uses 'folk' concepts of appropriateness to demarcate disorder (Bolton, 2008). In applying his theory, we would expect Wakefield to be drawing on the latest theories in evolutionary psychology, but instead, Bolton notices that Wakefield appeals to what is considered appropriate or normal, what makes sense, is meaningful, understandable, and what is not using explicitly social norms. We see again how easy it is to confuse our own customs with what is natural.

Here is Wakefield on separation anxiety disorder:

> "For example, a study of the mental health of children of military personnel at three bases that happened to take place at the time of desert storm, when many parents of the children- including in some cases the mothers- were leaving for the Middle East, where children knew that parents could be killed or injured. The level of separation anxiety was high enough among many of the children that they could clearly qualify as having separation anxiety disorder according to the DSM IV criteria; relative to typical separation responses common at their ages, their reactions were 'excessive', and 'developmentally inappropriate'. But in fact they could be considered to be responding with proportional normal-range separation responses to an highly unusual environment in which an extraordinary kind of separation was taking place and in which they had realistic concerns that the parents would never come back... There is no question that there are real disorders of the separation anxiety response, but the *DSM*'s criteria for separation anxiety disorder seems inadvertently over inclusive and reflect our values as much as they do genuine dysfunction in the child's anxiety mechanism" (Wakefield, 2002, pg158-59).

Interestingly, instead of drawing on evolutionary psychology models of the separation anxiety response, where the latest findings of cognitive neuroscience are put to use, what we see Wakefield doing is drawing on 'folk' notions of what counts as a reasonable response to a particular social situation, and what is deemed unreasonable, ununderstandable, and therefore potentially the result of a disorder. Instead of asking is the anxiety response functioning in a way that makes sense in evolutionary terms, Wakefield is asking the kind of things that are asked at the moment in the clinic. Drawing on notions of what is considered normal and reasonable. Is there something wrong in the individual here, or can we perhaps locate the problem in

the social conditions in which they live, perhaps how they are acting is reasonable and appropriate given the circumstances. Notions of appropriateness and normality that are necessarily related to the social world, and what, around here, is seen as human life that is going well, and human life that is unwell. Wakefield may be right in his critique here, it's just that his theory of mental disorder seems to play almost no role.

In addition to this, Bolton suggests that evolutionary psychology, and cognitive neuroscience, would not be able to answer the question involved here anyway for the conceptual reasons we looked at above. Such sciences are investigating phenomena that are already shaped by the social, such that we can't make the distinction Wakefield requires, namely, are we dealing with a genuine disorder, a dysfunction of a natural biological mechanism, the anxiety response, or is the problem to be located in the wider social conditions and circumstances? (Bolton, 2008). That is, has this mechanism gone off the rails, or is the mechanism doing what it is supposed to do, and therefore it is not within the individual that we ought to locate the cause of the problem, but rather in the anxiety producing circumstances in which they live in.

I now want to question the thought that we need to make a hard and fast distinction between disorder and non-disorder at all. Many of the conditions listed in the *DSM* may be understandable responses to adverse life circumstances such as we saw with the children of parents who have gone to war suffering high levels of anxiety as a result. The psychiatric profession can be of help here, so why does Wakefield want to make the distinction he does? Wakefield insists that true mental disorder is that which involves a complete lack of order, is simply disordered, is essentially meaningless. Although not explicitly stated by Wakefield this underlies his whole project. With true mental disorder some mechanism that allows for meaningful and understandable human life has somehow broken down. Imagine a series of pulleys and wheels where one of the wheels has broken in

half and the system no longer is able to function at all. What the counter-examples offered to Wakefield's analysis attempt to track is the idea that it is possible for the pulleys and wheels to be arranged, by adverse life circumstances such that the wheels and pulleys are working in such a way that, let us say this arrangement is at a port, damage is being done to various items at the dock. There is harm to the individual concerned- which too can often manifest itself in ways that harm others. People can develop psychological conditions that are harmful in the form of habits, conflicting beliefs (psychoanalysis) and that the mental health profession can be of help here. It is important however to not forget that it may be the context in which someone has a harmful psychological condition that should also be looked at, this being one of the chief motivations for the naturalist project, to make sure we do not simply see the problem as residing in the individual when in fact it is the wider context too that needs to be addressed. To repeat Wittgenstein's advice to Drury, "I don't want for one moment to underestimate the importance of the work you are doing, but don't ever let yourself think that all human problems can be solved in this way" (Drury, 1996).

The moral of' 'don't forget the wider context' can be maintained however without saying that all true disorder rests in, and can be defined with reference to the individual. This is what both Wakefield and Boorse's theories attempt to do in the notion of natural psychological function. The DSM is full of potentially understandable responses to adverse circumstances. For example, rape may lead to semi-permanent changes to someone's normal arousal response leading to avoidant behaviours and a heightened sensitivity to danger (Hinshaw, Richters, 1999). This may be perfectly understandable, and yet there may be significant harm because of these psychological changes, changes that the medical health profession may be able to help with. Simply plying the person with drugs may not be the best response (as though that is all the mental health profession has to offer), one needs to also look at the context of the person's life.

3.7 Derek Bolton and the naturalist project

Early in this essay I mentioned Derek Bolton's summation of the movement of the conceptual landscape over the last century with regards medicine and the mind. A dialectic has been in play between two broad pictures, understandings or representations of mental disorder. The two poles can be characterised in a number of ways. On the one hand, we see mental disorder as involving a fundamental lack of meaning, as an absence of order or meaning making. Mental disorder as a brute fact that imposes itself on our life, it has nothing to do with the mirror world (our shared world of meaningful connections), there is no conceivable point to them. Utilising a classical/physical/anatomical medical understanding, mental disorder is seen as the random and chaotic outcome of a disease lesion or process. Both Wakefield and Boorse accept this characterisation of mental disorder. Szasz too accepts this to some extent in that he accepts it as *the* understanding employed by psychiatry, it is just that he rejects the whole schema. On the other hand, we see mental disorder as tied with meaning and the mirror world through and through. Mental disorder is seen as understandable responses to life and this world of woe, albeit, responses that may seem bizarre, unhelpful, or even damaging to the individual concerned, and of course, potentially to those around them. This characterises two ends of a spectrum, with positions lying in between the two, meaning that there is ample room for positions where some conditions are viewed as fundamentally disordered while other conditions may be viewed as involving meaningful connections.

One of the principal critiques made by the anti-psychiatry movement was that psychiatry denied the possibility of meaning in madness. That it pathologised (rendered ununderstandable) what is at least sometimes, someone's meaningful reaction to the world—although someone like Szasz would argue that this is always the case with ascriptions of mental disorders, or there is simply a straight forward

case of physical disease- although we have seen how problematic this simple dichotomy is. Naturalism's response to this is to cleanly demarcate true disorder from something like Szasz's 'problems with living'. In doing so, writers such as Wakefield and Boorse have implicitly accepted the understanding of mental disorder whereby it is seen as having no conceivable point to it, it truly is, ununderstandable. The problem then becomes one of giving an analysis of the concept such that we know precisely when this is the case. We saw this above in the example of separation anxiety disorder in relation to children who had parents going to war that Wakefield discusses. It seems reasonable for children in such situations to feel high levels of anxiety and so the children's 'anxiety mechanism' is functioning as it should according to Wakefield. And so, Wakefield appears to suggest that the medical profession should keep clear. For there to be a true mental disorder, Wakefield is consistent in demanding that what is going on in the mind and actions of the individual concerned must have no conceivable point to it, there must be a complete break in meaningful connections. For only then is the medical picture appropriate- because again, the medical deals with the chaotic and disordered effects of natural processes.

Naturalism's tendency is to try and limit the domain of the medical to where there is a complete absence of order or meaning making. Why is this? I mentioned earlier that Bolton believes that the tensions that gave rise to the anti-psychiatry critique have been resolved through a synthesis, in the Hegelian sense, within the field of cognitive psychology. The problems people have that psychology can help with are intimately tied with meaning making, the conditions are adaptive, "I'm trying to get on in the world", but in such a way that harm of some form results. Western medicine, Bolton claims, was handicapped in its transition from a therapeutics of the physical body, to one of the mind (Bolton, 2008). For what modern western medicine owes its very success to is also what underpinned the difficulty of this extension. Here I refer to the natural sciences which have been built up around a picture (matter in motion, crudely speaking) that put

comprehension of mind and meaning out of reach. A number of things are going on here. We can perhaps think of Descartes' Dualism, and his difficulties in responding to Elisabeth of the Palatinate's questions over the relationship between an immaterial mind and the material world. Or of Leibniz' description of a machine "so constructed as to think, feel, and have perception, it might be conceived as increased in size, while keeping the same proportions, so that on examining its interior, [we] find only parts which work upon another, and never anything by which to explain a perception" (Leibniz, 1898, §17). The idea that 'the real' consists of matter in motion, Locke's primary qualities, and a reductionist spirit, both play a part in understanding why a medical science that grew up with such background understandings and assumptions would have the kind of difficulty Bolton identifies.

The anti-psychiatry movement objected to precisely this point, namely that psychiatry should be at all concerned with breakdowns in people's cultivated self, for such a self is defined through a social world, and an ideology (a notion of what there is, and what is worthwhile doing). This leads to the accusation that psychiatry is involved in moral or social policing, pathologising difference in order to legitimise the control of those that do not fit well into the dominant ideology of the day. I want to make a very tentative claim about part of the motivation behind the anti-psychiatry movement, one that I claim is grounded in a background of existentialist philosophy. There are two (amongst, I'm sure, many other) ideals in particular that induce an uneasiness about psychiatry. The first stems from John Stuart Mill's principle of liberty, and the second from what Charles Taylor calls "expressive Individualism", whereby the thought that one ought to find one's own way to live has become highly valued in our society. This is an ideology that has become dominant in the west, especially since the 1960s. Taylor sees the roots of such an ideology in the romantic movement of the 19th century in Europe (Taylor, 2007).If people's freedom ought to be only set by the limit that they do no harm to others (principle of liberty), and that one of the highest goods in life is

becoming who you are (expressive individualism), or finding your own way to live a full life, then the obvious concern regarding the mental health profession is whether or not they are in opposition to these two values or ideals. There is behind the anti-psychiatry movement a notion of what constitutes the good life.

We can also see how the anti-psychiatry critique could be seen as grounded in the goals of secularism, which Charles Taylor identifies as lying along the line of the goods characterised by the French revolutionary trinity. That is, liberty, equality and fraternity. I draw the following characterisations from Taylor. Liberty: no one must be forced in the domain of basic belief. Equality: there must be equality between people of different beliefs such that no world view, religion, or set of beliefs can enjoy a privileged status. Fraternity: all groups must be included in the ongoing process of determining what society is about, and how it is going to realise these goals (Taylor, 2011). Psychiatry is said to run counter to such ideals in that by applying the concept of mental disorder to someone we silence or denigrate someone's meaningful response to the world; a response that may involve beliefs about what the Good is (political, ethical), and what life is all about. This violates the ideal of liberty in that the methods of psychiatry force people into a certain domain of belief (for example what good conduct is regarding one's sexual life). This too violates the ideal of equality in society as certain ways of living are seen as falling within the rubric of mental disorder, thus delegitimising such beliefs, making them far from equal. And finally, psychiatry violates the ideal of fraternity by excluding certain marginal groups from the ongoing process of determining what our society is about, and how it is going to move towards such goals.

This is indeed a valid critique of a particular kind of psychiatry. However, it is only valid if we apply a model of mental disorder as fundamentally chaotic and disordered to individuals who are having problems that are meaningful responses to the world, labelling ununderstandable what is in reality understandable. Wakefield and

Boorse, I claim, continue to conceptualise mental disorder as fundamentally chaotic and disordered, and so, in responding to the anti-psychiatry critique they attempt to demarcate a domain where such an understanding of mental disorder can be truthfully applied. However, a shift away from the former to the latter understanding shifts the whole playing field, such that in so far as psychiatry is conscious of, and sensitive to the psychiatric critique, the project of Wakefield and Boorse becomes essentially redundant. There is no longer the danger of applying a concept that understands someone's behaviour as fundamentally chaotic, disordered, and meaningless, to where there is actually meaning, because we have dropped *that* understanding from our conception of mental health problems.

If we accept the role of the social in mental health care Derek Bolton suggests that many of the conditions described in the DSM may be normal enough responses to adverse life events, may be understandable, and in light of that, meaningful, in so far as we focus on the harm caused by a psychological disposition and the need to treat (as opposed to the question of whether we have a true disorder in Wakefield's sense). The medical model was problematic in its extension from the physical to the mental, and so writers such as Wakefield and Boorse have tried to maintain the traditional psychiatric picture by attempting to define 'mental disorder' in a manner that in a sense excludes the world of meaningful connections, rules out completely ethical/spiritual understandings, so as to not slip in to the problematic identified by the anti-psychiatrists.

What Bolton claims is that this project is not needed because we do not need to cling to the old medical model. That is, we expand or evolve our notion of what medicine is. The psychological science of psychopathology is a scientific discipline that grew up alongside the 'medical' or biomedical picture of the mental and saw meaningful connections as running through many of the problematic conditions that psychiatry saw. The problems that the mental health profession deal with are intimately tied to spiritual and ethical concerns, about

what is significant in life, and what is considered to be the Good. There is always a context to consider, judgements to be made about what is appropriate behaviour, what is not, what does it mean to live well and so on.

Referring back again to our example of separation anxiety disorder and Wakefield's claim that the *DSM* by failing to take into account context, can lead to someone making a diagnosis of 'separation anxiety disorder' where, by our lights, such levels of anxiety could be seen as quite understandable and appropriate. We diagnose them as having a dysfunctional anxiety producing mechanism, when in reality, it is functioning just fine, it just so happens that the parents of the individual concerned are away fighting in a war. A situation which of course is going to lead to high levels of anxiety. We again diagnose ununderstandable what is in reality an understandable and meaningful reaction to life. This is only the case however, if we equate a diagnosis of 'mental disorder' with 'ununderstandable' and of no conceivable point, that is, meaningless. "I cannot possibly understand why you are thinking and behaving as you are, there must be a malfunctioning natural mechanism". However, if we don't make this equation, we can see meaning here, we can try and understand, and to help. We broaden our medical picture (think of psychoanalysis and cognitive psychology) and we need no longer run up against this wall. The important question now becomes, not, is there a disorder of a natural mechanism to which we can apply our medical representations (at the exclusion of all others), but rather, is there a need for help here, and if so, can our (now expanded) medical understandings be of some help?

Here's Bolton:

> Disorder attribution can depend on assessing proportionality –often a fine judgement. The more important questions from the clinical point of view are whether there is a need to treat, turning on the question of significant harm (for example, frequent unmanageable distress, not going to school, not

> able to go out with friends), and if there, whether treatment should aim at modifying an inappropriate anxiety response or to help adjustment to what is a reasonably realistic perception of threat. In the first approach the therapeutic aim is change, and the communication could be something along the lines: 'let's try and find out whether mummy really is in as much danger as you fear (for example when she leaves the house, having recently been the victim of an assault)- Let's go into it all and find out'. In the second the primary aim is containment of anxiety, and secondarily, better (less interfering) coping, for example along the following lines: 'I can see why you are so worried about your mother (what with her going to war and all), and you (the remaining carers and child) have to spend time thinking about mother and what she is doing, not all dangerous- and while we are about it or at other times we have to try and get on as best we can, trying to go to school, getting on with homework, seeing friends'. All this is just clinical work involving judgements about proportionality, context, harm caused, need to treat, treatment tact- all involving opinions about norms of child and family functioning in particular kinds of environments, and values about harm and need to treat. Nothing I see here fits well with the idea that in some cases we have a real disorder of natural functioning, in others projections of values. (Bolton, 2008, pg144).

With this in mind Bolton questions whether the name 'mental disorder', is really appropriate for the conditions described in the DSM at all. For this name seems to suggest too readily a medical picture that draws too many connections with the traditional biomedical/anatomical understanding of health and disease. And it is precisely when we apply this picture to many of the problems that psychiatrists try and help with that we run into trouble. In light of this, Bolton suggests as an alternative perhaps 'mental health problems', something that can convey the notion of harmful psychological conditions that does not simply connote meaningless and mere absence of order (Bolton, 2008).

The conclusion that Bolton works towards throughout 'What is Mental Disorder' (Bolton, 2008), is one that plays down the thought that mental disorder is a natural entity with a discrete nature that can be picked out and defined or circumscribed in the manner that both Wakefield and Boorse attempt to do. What Bolton claims is that the proper domain of the medical health profession is defined "fundamentally by a distinctive kind of response to problems, rather than by a distinctive kind of problem"(Bolton, 2008, pg195). This is to say, the domain to which the mental health profession directs its energies is not defined by the nature of the problems it deals with, but rather, again, by the nature of the response. The troublesome question of whether or not mental health services confuse medical/healthcare problems with social problems, or ordinary problems of living, only comes up in its stronger forms if we think that people's problems can be sharply demarcated here between the two possibilities presented. However, if we think of the domain of psychiatry as being characterised by a particular kind of response, rather than, Bolton suggests, by a particular kind of problem to be kept distinct from social, ethical, political, and spiritual difficulties, then it becomes less pressing to answer the accusation that psychiatry confuses the two domains. There aren't two distinct domains to be kept separate here.

This may seem circular in that Bolton suggests we define the domain of psychiatry by what psychiatrists do, and potentially dangerous a critic of psychiatry might add. This however is a political problem, the character of which I mentioned in the introduction in relation to psychiatry in the former Soviet Union. This is a different kind of problem and not one I am addressing in this essay, but again briefly, it can be mitigated by such things as judicial review where a second source of considered opinion is offered and where conflicting views can be debated. The approach I am advocating here is only circular if what we are trying to do is define a domain of *exclusively* medical problems to which *only* medical representations and understandings ought to be applied. However, if we follow Bolton's advice, this is not

necessary. The notion of exclusivity here is important. The solutions that are often given to the 'troublesome' problem within psychiatry assume such exclusivity. That is to say, we are trying to say what it is that medical representations ought to be solely applied, at the exclusion of all other understandings, ethical, spiritual and so on. So that when I understand someone as having a mental disorder, perhaps as being depressed, I see this as completely unconnected to spiritual matters, all I see is a medical problem, that is to be dealt with along medical lines in order to make the person better. Making the move Bolton makes here is to deny such exclusivity, that is, although medical understandings are of help with the conditions described in the *DSM*, it by no means means that other forms of understanding such problems are not too as equally valid (or indeed the suggestion that there is no problem at all).

Kristen Steslow makes a similar observation when she writes that

> Under the right circumstances, a diagnosis can be a very good picture, and as a provisional truth on which to rest some of the weight of medical inquiry, it serves a worthy therapeutic purpose. A good diagnosis highlights salient features of a patient's experience, provides a framework for understanding them, and allows the clinician both to intervene and to make logical inferences and predictions based on previously accrued knowledge about other patients whose experiences resembled this one. But the best diagnosis is a particular interpretation of the phenomena in question (Steslow, 2010).

We saw this in the case of the priest Drury describes who was depressed because he was losing his faith. Drury thought he could do something to help, that is, he felt he could assist using his psychiatric training. This man was suffering from a problem to which the medical representations Drury was familiar with were helpful. Indeed, as we saw, Drury has great success, and sees the priest back to the monastery full of passion and devotion for his works as a priest. This however

did not mean for Drury that a diagnosis and successful treatment of depression told the full story. While Drury did indeed think that his expertise as a psychiatrist could be of assistance here, he by no means thought that because of this the priest's problem was therefore simply a medical one and not a spiritual one. This chimes well with the notion that psychiatry is a particular way of viewing problems, problems that do not necessarily have to be strictly seen in such a manner.

This answers the anti-psychiatry critique that psychiatry strips the possibility for other kinds of meaningful understandings, that it dehumanises people (Szasz). Indeed, Drury considered this to be a common prejudice, namely, "that a mental illness is a degradation of the total personality; that it renders the sufferer subhuman" (Drury, 1996, pg135). This prejudice denies room for the possibility of meaning in madness. Hence the critique that psychiatry flies in the face of the ideals embodied in the revolutionary France trinity. This prejudice, Drury suggests, would lead to the conclusion that if Tolstoy really did suffer from melancholia or depression then "his challenge to our whole western way of life would be largely blunted and nullified"(Drury, 1996, pg135). What Drury argues for is that a mental disorder can in itself be a religious experience. That the terrifying loneliness and vulnerability involved in the reality, and indeed the possibility of, mental disorder in our own lives can be an experience that can be highly spiritual, and indeed, make us "more aware of the mysteriousness of our present being" (Drury, 1996, pg136).

Psychiatry is defined here by a particular way of viewing problems, and by a particular practice that has been built up around people seeking help at an individual level. We can carry out an investigation into the character of this practice, what is it that psychiatry does, what is it good for, what are its limitations. These, I claim, are more useful questions than trying to define an exclusive set of problems that only psychiatry can deal with.

3.8 The spirit of our enquiries

If psychiatry is thought of as being defined by the kind of response it makes to people's problems, rather than the by the nature of the problems themselves, are we not left with a situation in which anything could be called a mental disorder? Some people, even today, think of homosexuals as fundamentally unwell or sick, and in need of medical attention. We could counter by suggesting such people have failed to track the Good, that is, such people have failed to realise that homosexuality can be part of a good human life. The move here is to acknowledge openly the role a notion of the Good plays in psychiatric judgements. Central to much of the criteria of the DSM is the extent to which a particular manifold of behaviours is considered harmful. The reason homosexuality was removed from the DSM was that it came to be seen as an acceptable manner of living. The sexual revolution and the relaxation of social mores associated with the church played a defining role in this. Are we not left then with what counts as being appropriate left to the whim of subjective judgements of value? Not necessarily. This move can be made by rejecting a relativist or subjectivist account of the Good. The idea that the 'Good' is ultimately a matter of opinion is a particular understanding of ethics traceable to an existentialist understanding of the self. Fulford sums this up as the "facts good, values bad" approach (Fulford, 2000). Murdoch argues that there is a deep flesh to human existence, drawing on Aristotle, that allows us to say concrete and objective things about what the Good is for a human being (Murdoch, 1970). Very briefly, the thought is that there are certain facts about humans as natural animals, the way we are, that fixes, to a certain extent, what the Good is for us. Such meta-ethical reflection goes well beyond what I can look at here, There is scope for reasonable debates about values, about what ought to be considered harmful and in need of medical treatment, and manners of living that ought rightly to be considered to fall within the Good of human existence.

The problem we began this essay with is only answerable by looking at individual cases and asking, 'is the medical response appropriate here, in this particular case?' For both Drury and Bolton this question is a complicated matter depending on the multifarious contingencies of a particular case. A significant consideration is the harm caused to the individual which motivates treatment. For Drury the priest's condition was such that he felt there was justification for medical intervention to help this person cope with what they were going through. This by no means for Drury detracted from the reality of the priest's spiritual crisis however. Care does need to be taken in that a fine line is being trodden here-the image Nietzsche left us of the 'last man' who doesn't feel any deep spiritual dimensions of existence should caution us against going too far (Nietzsche, 1995). On the other hand, Drury saw no need for psychiatric treatment for the retired civil servant he saw who had gone on a pilgrimage after finding truth in the words of the gospel. Of course, these are fine clinical judgements, and there is no algorithm as such that can help one tell what to do when presented with a case. To repeat Bolton, such cases involve judgements of proportionality, harm caused, and the wider context. The distinction between cases where there is a 'real' disorder of natural functioning, and in others simply a projection of values, that is to say, what we see is only bad because of the dominant ideology, seems too be of little help here. We have changed what it means to call someone mentally disordered, especially under the influence of contemporary cognitive psychology, such that this distinction is no longer necessary.

4 Shifting the Focus: Mental Disorder in Relation to our Manner of Life

When in philosophy you keep coming up against a dead end, such as we have so far, in our search for a principle of differentiation between madness and religion, it is often because we are looking for *the wrong type of answer.* And this is what I believe we have been doing in our search. For we were sitting back in a cool hour and attempting to solve this problem as a pure piece of theory. To be the detached, wise, external critic. We did not see ourselves and our own manner of life as intimately involved in the settlement of this question [emphasis added].
-M. O'C. Drury, *Madness and Religion in 'The danger of Words' pg132-33*

The more narrowly we examine actual language, the sharper becomes the conflict between it and our requirement. (For the crystalline purity of logic was, of course, not the *result of investigation*: it was a requirement.) The conflict becomes intolerable; the requirement is now in danger of becoming empty.- We have got onto slippery ice where there is no friction and so in a certain sense the conditions are ideal, but also, just because of that, we are unable to walk: so we need *friction*. Back to the rough ground!
-Wittgenstein, *Philosophical Investigations, § 107.*

The real discovery is the one that makes me capable of stopping doing philosophy when I want to.-The one that gives philosophy peace, so that it is no longer tormented by questions that bring *itself* in question.-Instead we now demonstrate a method, by examples: and the series of examples can be broken off.- Problems are solved (difficulties eliminated), not a *single* problem.
-Wittgenstein, *Philosophical Investigations, § 133.*

It is a traditional axiom of medicine that health is the absence of

disease. What is a disease? Anything that is inconsistent with Health. If the axiom has any content, a better answer can be given. The most fundamental problem in philosophy of medicine is, I think, to break the circle with a substantive analysis of either health or disease.
-Boorse, *Health as a theoretical Concep, pg 542*

The concept of a disorder is not the same as a theory of disorder. Physiological, behavioural, psychoanalytic, and other theories attempt to explain the causes and specify the underlying mechanisms of mental disorder, whereas the concept of disorder is the criterion to identify the domain that all these theories are trying to explain.
-*Wakefield, The Concept of Mental Disorde, pg374*

4.1 Anti-psychiatry, naturalism, and examining the question of 'what is mental disorder?'.

At the heart of much of the debate we have looked at so far there is a central question, and in that question, I believe there to be, potentially, a fundamental mistake or misunderstanding, perhaps better put as a certain blindness to the dialectical possibilities that lie before us. Here, I don't want to take issue with the answers that have been given to the 'fundamental' question, as Boorse puts it, in the philosophy of medicine, although as we have seen there are certainly problems with the answers that have been given, but rather, with the question itself and the *kind* of answer we have been looking for. This is on that is essentially couched in terms of correct or one true definition of mental disorder.

There are two guiding ideas that characterise the point from which both Boorse and Wakefield start their respective projects. In the following I will question both of these guiding ideas. The first is an assumption that the kind of things mental health practitioners ought to be dealing with ought to be something that exists in a manner independent of any particular social order, values, or subjective

judgements: mental disorder as biological fact. I argued in the previous chapter that mental disorder is best understood as being intimately tied to the social order, to value judgements, and the world of meaningful connections. Hand in hand with this is the understanding that mental disorder must represent a complete break from the normal human psyche. The walls surrounding the asylum of yore embody this assumption or understanding: the mad as inhabiting a 'separate world' (Grant, 2001). The second is that the concept 'mental disorder' *must* refer to something that has a determinate nature, and that our problems with distinguishing for example, madness from religion, will be answered once we have uncovered or defined the real contours or nature of mental disorder. Think of 'mental disorder' as a tag for something, we will know where to put the tag once we have fully described or analysed the nature of what that something is. However, do words really work like this, does giving the correct definition of 'mental disorder' really get us anywhere? Taking a Wittgensteinian approach, I propose in this chapter to undermine this second guiding principle. But first of all, I will look further at the notion that mental disorder should be conceptualised as a biological fact.

Both Wakefield and Boorse offer highly theoretical approaches that look for a single answer to the question of 'what is mental disorder?'. However, following Bolton, I am going to suggest that the application of the concept of 'mental disorder' is something that is related to a whole slew of clinical judgements to do with social and ethical norms, harm to the individual, contextual factors, the potential benefits of treatment and so on, all drawing upon judgements that reflect our, as Drury claimed, *manner of life*. This is a shift from attempting to find an independent standard which will guide our psychiatric practice, to the thought that good psychiatry comes about, not from discovering such a standard, but rather from a fuller understanding of the contours and context of its own practice, a conscious awareness or reflective understanding of how it is, again, that our own manner of life is so tied to the sort of clinical judgements mentioned above.

The chief concern of the anti-psychiatry movement was that by labelling what is meaningful as meaningless, a medical gaze that lacks understanding becomes capable of violence to those who were often the least able to speak for themselves or make themselves heard. This violence is done through the way the label of mentally disordered can dehumanise someone, making what they say and do somehow not worthy of having a place in the world of goodness and truth. Someone's thoughts and actions are labelled ununderstandable when in fact they are understandable. This concern is too shared by both Boorse and Wakefield, who, as we have seen, try and draw a neat line between the two, between when there is meaning in someone's actions, and when such actions can be conceptualised as the meaningless breakdown of a natural function. It is important however to also be aware too of the way medicalising someone's problem can also protect them, for example, from blame they do not deserve. It is not necessarily always seen as negative. A diagnosis can be reassuring in that it allows someone's troubling experience to be rationalised, 'I have condition X, there are many other people out there who suffer from it, and there are trained professionals who are here to help me'.

To what degree should mental disorder be thought of as a complete absence of order or meaningful connections? We saw in Professor William Griesinger's uncompromising statement that "mental illness is cerebral illness" a strong somatic model of mental disorder which tends to picture mental disorder as some form of breakdown of natural processes, a position which historically has been associated more strongly with psychiatry than psychology. The superintendents appointed to administer asylums in New Zealand during the last decades of the 19th century believed that insanity was a physical disease. There was a strong resistance to psychological approaches, "the Victorians argued that disordered mental states were themselves beyond rational scientific understanding, but that science could understand the bodily processes which gave rise to them- the underlying disease attacking the brain and nervous system" (Philp,

2001, pg188).

The naturalists in the sense in which they reduce mental disorder to a complete absence of order, to the meaningless and chaotic or disorganised effects of a disease process accept Szasz's critique fully. However, the picture of mental disorder that is in the background of Boorse's and Wakefield's approaches, in an ironic sense rather than being a synthesis, is more of a continuation of the thesis- namely that which the anti-psychiatry movement tried to bring to our attention, where the medical picture as such, or at least as it was, is seen as inadequate in dealing with the human psyche (or soul). Naturalism is an attempt to hold onto this medical picture, either by in the case of Wakefield and Boorse, formulating an understanding of the natural functions of the mind, or, by reducing all psychiatric thinking to the physical sciences, that is, to biomedicine (neuroscience). Mental disorder represents a complete break from the rest of the human world.

There are a number of ways to cut the conceptual pie here. One option is to agree to this: namely, that the medical picture is inadequate for thinking about the human psyche or soul. Szasz takes this line, and so, in a sense, do Boorse and Wakefield. All three agree that the medical picture is totally inadequate for dealing with the soul. Szasz takes this to mean that we should stop talking about mental disorder at all as this notion is intimately tied to questions of the human soul, moral, political and so on. Boorse and Wakefield on the other hand, while accepting that the medical picture is inadequate to deal with questions of the human soul (which involve moral and political elements), believe that it is possible to separate out the human psyche into the part that is natural and the part that is cultural such that we can talk of the human psyche without bringing in political and ethical elements. The idea of natural function with reference to our mental capacities is supposed to do this. I argued in the previous chapter that there are significant difficulties with both Wakefield's and Boorse's approach, specifically in the attempt to make a distinction between natural

psychological processes/functions and what is culturally defined, that is, what is the product of being socialised into a particular manner of doing things.

The second option for cutting the conceptual pie is to agree that the medical picture that the anti-psychiatry movement was critiquing was indeed inadequate for the subject matter it was attempting to deal with. That to try and see it as insulated from cultural, ethical, and political considerations was to fail to attend to the truth of the matter. However, if we see the medical picture as having evolved in such a way as to be able to respond appropriately and to be sensitive to the reality which it encounters with all of its social, cultural, ethical and political currents, then the playing field in a sense changes- a synthesis occurs. This is a medical picture that accepts that what it deals with often lies much along the lines of what Szasz would call 'problems with living', that is, the difficulties people have with getting on in, and coping with, the reality in which they find themselves. Those suffering from mental disorder do not live in a 'separate world', the closure of the asylums and the integration of the mentally unwell into the community can be taken as an embodiment of this shift. The asylum wall has come down, making the project of defining strictly which side of the wall one ought to be on, vis-à-vis Wakefield/Boorse therefore less pressing.

The anti-psychiatry movement brought attention to the role of the meaningful in the kind of things the mental health profession were engaging with (Fulford, Graham, Thornton, 2006). We see this in for example the psychological model whereby mental disorders are seen as learned abnormalities of behaviour, and therefore, the disease picture, in agreement with Szasz, is inappropriate. Bolton stresses this point, claiming that in a way, the cognitive psychology that has developed over the last 30 or so years has resolved (or dissolved depending on how one looks at it) the debates and critiques that were sorely needed in the 1960s. This is what Bolton refers to as a synthesis. Of course this is not to say the debates of the 1960s are

irrelevant now, rather they are an integral part of the synthesis of today. Our picture of mental disorder has evolved in response to such critiques.

There are two approaches I have been outlining here. 1)The first takes 'mental disorder' as something that is a 'natural' phenomenon, or 'natural kind'. Wakefield and Boorse attempt to track this. Szasz to a certain extent accepts this too, except for him, the reasoning is, mental disorder conceived of as a natural entity is the only way to think about mental disorder, and this way of thinking about it is a myth. This is the naturalist approach. 2)The alternative is to not think of mental disorder as a 'natural kind'. A natural kind is generally thought of as something that is objective, independent of the observer, is not relative to a particular manner of life, or ideology. With 2 there is no matter of fact that can pull apart true mental disorder from all the various entanglements the concept seems to have with social, ethical and political factors. There are no strict borders to the concept. How can this be? This makes sense, I claim, if we think of the concept as being grounded in a practice. This is where a Wittgensteinian understanding of the topic comes in. The domain of psychiatry, what its concepts apply to, rather than being defined by a particular kind of problem, are rather defined by the nature of the response to those problems. That is, the concepts are defined by the nature of the practice in responding to problems, problems that are diverse, and encompass social, political, ethical and biological elements. With 2, there is a fundamental shift in the kind of question that is pressing for psychiatry. Rather than asking "what is mental disorder", we now ask, "When is the medical response appropriate?". We see this approach in Drury. With the corollary that the 'medical response' is quite a multi-faceted thing, involving more than just surgery and the use of drugs.

4.2 Conceptual analysis and mental disorder

Echoing Drury, the problems we saw in the previous chapter are

because such an approach is "looking for the wrong kind of answer" (Drury, 1996). This, as we saw, is Drury's response to the troubling question over how to properly make a distinction between genuine cases of mental illness or disorder, and what on the other hand ought rightly to be considered genuine religious experiences (or we could say here, spiritual matters- questions of how we ought to live (what to do with ourselves)). There is a body of literature surrounding the debate over whether the idea of discovering the true or the real contours of the concept of mental disorder is the best way to settle once and for all the kind of problem that Drury describes (Boorse,1977;Clark,1999;Cooper,2001,2008; Cosmides, Tooby,1999; Fulford,1999; Kirmayer, Young,1999; Klein,1999;Lilienfeld, Marino,1995,1998;Richters, Hinshaw,1999;Sadler,1999;Sadegh-Zadeh,2000,20008; Spitzer,1999;Wakefield,1992a, 1992b,1999,2000). It is an intuitive and persistent question that comes up. If only we had the right, true, correct, definition of mental disorder, would we then be able to conduct psychiatry in a rational manner. From here I intend to make this question appear less intuitive.

The failure to settle debates once and for all over the scope of the psychiatric profession, and what is to count as mental illness or disorder, is thought of as being the result of "a failure to reach a consensus on the definition of mental illness" (Lilienfeld, Marino, 1995, pg411). Wakefield explains what he means by 'conceptual analysis' as a process whereby "proposed accounts of a concept are tested against relatively uncontroversial and widely shared judgements as to what does and does not fall under a concept" (Wakefield, 1992b, pg233). By doing this a criterion, or set of criteria can be formulated which govern the application of the concept. The ultimate success of such an analysis is judged by the success it has in explaining such uncontroversial judgements. For example, we could say that the concept 'house' has a number of criteria that an object must meet for it to be considered as such, it must have a roof, a door, walls and so forth. An adequate definition allows one to use the concept correctly, that is, in a manner that successfully tracks the truth. For Wakefield,

such a criterion for mental disorder is found in the notion of natural function which is related to evolutionary theory, and the breakdown of such natural functions. Much of the literature has focused on this approach to the problematic regarding the proper scope of psychiatry. A concept that is treated in this manner is known as a classical concept. 'Bachelor' is a straight forward example of this, the criteria that govern the use are 'unmarried' and 'male adult'.

Lilienfeld and Marino have disputed this approach, arguing that the concept 'mental disorder' is not this kind of concept, and is therefore not amenable to this kind of analysis, arguing that 'mental disorder' is a Roschian concept (Lilienfeld, Marino 1995,1999). A term which comes from the cognitive psychologist Eleanor Rosch who studied how people identify and categorize objects. When asked to identify an object of a particular type, for example birds, some are more readily identified with the category than others. For example, a sparrow is more readily identified as a bird than a penguin. The thought is that we do not have a highly theoretical abstract picture of the concept bird (a strict definition or set of criteria) which informs what we consider to be a bird, and what we do not. Rather, we a have a number of central or prototypical bird images, and it is resemblance to these that informs our bird categorizing. Lilienfeld and Marino argue that our concept of mental disorder is much like this, having no clear cut counter part in nature. Some mental disorders are prototypical such as schizophrenia and depression, and are widely identified as such, while other conditions are more at the borderlines of the concept, such as conduct disorder, or indeed, homosexuality, which in the past occupied such a position. The point is that no amount of analysing the concept of mental disorder will help us tell what ought to fall under the concept in a definite and final manner as there is no definite set of underlying principles that determines concept membership.

Wakefield however objects to this approach by pointing out that there is no account given of how similarity is to be judged (Wakefield, 1999). How similar does something have to be to a prototype to be

considered a disorder? Wakefield insists that there must be some kind of criteria that can guide our use of the concept that is independent of values and so forth. Lilienfeld and Marino do offer, in a sense, a sort of criteria or guiding principle for inclusion in the *DSM* centering on harm to the individual, that is, there must at least be harm to the individual concerned. However, this is not going to provide any kind of definitive answer to what ought to be considered as mentally disordered. In response to Lilienfeld and Marino, Wakefield proposes what he calls a black-box essentialist account of concepts. He uses the concept of water to demonstrate this. There are a number of features of water that allow us to identify something as water. It is a liquid, is transparent and so on. There are other things that are too a liquid and transparent, and yet, so the argument goes, we don't consider such things to be water- despite how much they may resemble our prototype notion of water. Ultimately, the concept of water is held together by its nature. That is underlying the concept is the fact that all water consists of the molecule dihydrogen monoxide. "Concept membership is determined not by the observable properties that may have inspired us to define it in the first place, but by an essentialist property that explains the observed features (Wakefield, 1999, pg469). Wakefield claims that for mental disorder 'natural function' (analysed in an evolutionary way) plays the role of the water molecule.

Lilienfeld and Marino do accept that it is conceivable that "consensual judgements of disorder are an imperfect reflection of a clearly demarcated category in nature, and that researchers will eventually succeed in identifying an explicit scientific basis for disorder" (Lilienfeld, Marino,1995,pg416). However, the repeated lack of success of many highly capable individuals in demarcating the natural boundary between the normal and the pathological is reason to believe that the concept of mental disorder lacks any such clear cut natural boundaries. Wakefield's response is to claim that he has actually characterised such a natural boundary- as he sees it he successfully fends off all of Lilienfeld and Marino's technical and conceptual objections to his theory. What I want to do is from here is argue for

and make sense of the thought that there is no 'natural object' that mental disorder refers to and that 'conceptual analysis' is a misguided attempt at making psychiatry a rational/scientific enterprise.

This whole problematic of conceptual analysis is shifted however if we start thinking of 'mental disorder' as being something that informs a particular way of looking at a problem, rather than being something that constitutes a particular kind of problem in itself. To ask "what is the true character of the 'object' the word 'mental disorder' delineates?" is to be asking the wrong kind of question. The movement of thought is as follows. *Psychiatry is defined by the particular way it views a problem, not by the nature of the problem itself. Conceptual analysis is an attempt to define the nature of the problem- mental disorder. This can't be done because the problem itself is not what defines the domain, but rather the practice of psychiatry.* The concept of mental disorder is not held together by an 'image' of mental disorder, but rather by a practice and our manner of life that informs that practice. I argued in the previous chapter that mental disorder is defined by reference to social, ethical and political norms. These two points taken together mark a distinctive shift in our thinking from the debate couched in terms of conceptual analysis.

The appeal of offering an 'analysis' of mental disorder is squarely rooted in the analytic tradition, in particular the one envisaged by Russell where the role of philosophy consists in the analysis of big things into little things, whereby we have explained the various uses of a concept (a multiplicity) by grounding it in a chunk of matter, in a single, isolated bit of the world. On this picture of language, the fundamental notion of what language is can be located in the idea of representation. Parts of language here can be thought of as having an isomorphic relation to reality. Each word represents a definite and isolable chunk of the world. Much of what philosophy is said to be of use for here is getting the logic of words correct. An analysis involves getting our representation, that is, the logic of our words to match up to the logic of the world. Wakefield conceptualises his project in this

manner. One finds the true or real nature of what a concept refers to, that is, analysing a concept to find out what it is *really all about* makes perfect sense, indeed, a concept must admit of such an analysis. By clearing up the logic of a word we get the referent right, that bit of the world that the word is meant to connect to, map on to. Such a conception of language and philosophy is what underlies the attempts to analyse the concept of mental disorder.

This is seen by critics of such a view as attempting an external point of view on language, where on the one hand we have language and on the other the world, and what we hope to do is see how one relates to the other so as to bring language in line with the world. What this approach fails to recognise is that concepts are not necessarily simply name tags for objects, that they can also be thought of as being grounded in a practice, in what we do. Acknowledging this undermines the intuitive thought that it is a proper definition of mental disorder that will solve our problem as to the proper domain of psychiatry.

What Rorty calls 'Pragmatic Wittgensteinians' tend to think that there is "nothing useful to be said about the relation between two large entities called "Language" and "World". There is however, Rorty goes on to add, "a lot to be said about our linguistic behaviour" (Rorty, 2007a, pg173). The fundamental question now becomes, not 'what *is* disease?', or 'what *is* mental disorder', but, 'when is the medical response appropriate?'. How ought *we* use the concept of mental disorder, rather than, what natural fact is there out there that dictates our use of it. This is not to say that the question of “what is mental disorder?” is a nonsense, it is rather, simply to say the answer will not necessarily, as Wakefield and Boorse assume it must, come in the form of a neat set of objective criteria for the concept's use.

> But if, as Wittgenstein suggested, a concept is just the use of a word, and if the proper use of a word that interests philosophers is always going to be a matter of controversy, it

> is not clear that "analysis" is an apposite term for what philosophers do. For a philosopher's claim to have discovered the contours of a concept can never be more than a suggestion about how a word should be used. Philosophers' diagnoses of "conceptual confusion", as well as their claims to have achieved "conceptual clarity" look, from a Wittgensteinian point of view, like disingenuous ways of going about the transformation of culture, rather than making clearer what has been previously going on (Rorty, 2007b, pg180-81).

Confucian philosophy, long before European or Western philosophy became philosophically (or reflectively) aware of language, saw the role language plays in the 'determination of our way(s) of seeing the world'. Instead of asking questions about what something *really* is, the question of "how should we call something?" is more natural. Words have ideals built into them (Solomon, Higgins, Marie 1996). What does analysis look like when we have moved away from classical analytical philosophy? Drawing again from Rorty, "Hegel taught us how to think of a concept on the model of a person- as the kind of thing that is understood only when one understands its history" (Rorty, 2007b, pg182). We learn about someone, and can begin to understand their behaviour only once we have learnt about where they have come from, have a story about their past. In much the same way, in terms of conceptual analysis, we learn the most when we are told a story about how the uses of a set of words have changed in the past,

> as a prelude to a description of the different ways in which these words are being used now. The clarity that is achieved when these different ways are being distinguished from one another, and when each is rendered intelligible by being placed within a narrative of past usage, is analogous to the increased sympathy we bring to the situation of a person whose life-history we have learnt (Rorty, 2007b, pg182).

It is with this in mind that I claim good and true psychiatry comes

about through a fuller understanding of the contours and context of its own practice, rather than the guidance of that practice by an order independent of that practice in the form of a definitive analysis of the concept of mental disorder.

4.3 Wittgenstein and the 'rough ground'

The trouble now, it can be objected, is that it seems to be that we are in danger of losing the concept altogether. By arguing that there is no essence or essential nature to 'mental disorder', that mental disorders form a continuum, and meshes with all the other kinds of problems we have with getting on in the world, how is the concept used at all? How do we know when to use it and when not to use it. The question arises again, there must be *something (objective)* that marks out a domain where psychiatric attention is warranted? The thought here is that there must be something that ties the concept of mental disorder together, and that if only we could correctly analyse the concept, we would know exactly when, for example, the priest Drury saw had depression or not- or indeed, whether or not depression is a true mental disorder in the first place. The shift in understanding I argued for in the previous chapter on naturalism, from seeing mental disorder as a natural kind, the nature of which circumscribes the psychiatric domain, to an understanding that sees psychiatry as circumscribed by the kind of response it makes to people's problems, the kind of representations and techniques it uses, leaves us in a position where the concept of mental disorder could be applied to anything and everything. Without a natural kind on which the psychiatric profession can focus, is it not in danger of losing its credentials as a rational enterprise?

A Wittgensteinian understanding of this debate can provide some foundations for the approach I am taking. The addition Wittgenstein makes to the prototype approach of Lilienfeld and Marino is the thought that what we call mental disorder is connected to a deep tissue

of what we say and do (the rough ground), our form of life, and is more than just a matter of judging similarity to prototypical cases. What Wittgenstein can help us with is move away from the project that is couched in terms of analysing the concept of mental disorder as though there simply must be a single objective thing to which the concept refers.

A parallel can be drawn between Wittgenstein's investigations into language, that could for our purposes be summed in the question 'what is language?', in his *Philosophical Investigations* (Wittgenstein, 1953) and our general question 'what is mental disorder?'. Throughout the *Philosophical Investigations* Wittgenstein gives us examples of how language could be and is used, but at no point does he tell us what all these activities we call language have in common, what is the underlying feature? Here is Wittgenstein:

> Here you come up against the great question that lies behind all these considerations.- For someone might object to me: "You take the easy way out! You talk about all sorts of language-games, but have nowhere said what the essence of a language-game, and hence of language, is: what is common to all these activities, and what makes them into language or parts of language. So you let yourself off the very part of the investigation that once gave you yourself the most headache, the part about the *general form of propositions* and of language."
>
> And this is true.- Instead of producing something common to all that we call language, I am saying that these phenomena have no one thing in common which makes us use the same word for all,- but that they are *related* to one another in many different ways. And it is because of this relationship, or these relationships, that we call them "language". (Wittgenstein, 1953, §65).

We have a strong intuition that an investigation into the general form of propositions, the essence of what language is, will admit of a single

answer. We see Wittgenstein here being pressed with that demand. This parallels the intuition that there must be something that underlies all ascription of mental disorder, a criterion, or natural feature, that if only we could accurately describe, the kind of problems we saw Drury grappled with would then admit of a definitive answer. We have a single word, a single concept, so there must be something independent of our actual practice that is the true home of the word, that is, the correct definition, what the word really is about. This however only follows if we have a name-tag approach to language, where the essence of language is considered to be an association of words with objects. Chair, apple, Moon, Earth, Car and so on- the picture of language Wittgenstein begins his Philosophical Investigations with. What is the 'object' associated with the term mental disorder? Following the above quote, Wittgenstein explains what he means by asking us to look at the word 'game', and asks of us, in general, whether or not there is anything that defines the essence of 'game'.

> Consider for example the proceedings that we call "games". I mean board-games, card-games, ball-games, Olympic games, and so on. What is common to them all?- Don't say: "There must be something common, or they would not be called 'games' "-but *look and see* whether there is anything common to all.-For if you look at them you will not see something that is common to *all*, but similarities, relationships, and a whole series of them at that. To repeat: don't think, but look! -Look for example at board-games, with their multifarious relationships. Now pass to card-games; here you find many correspondences with the first group, but many common features drop out, and others appear. When we pass next to ball-games, much that is common is retained, but much is lost.- are they all 'amusing'? Compare chess with noughts and crosses. Or is there any winning or losing, or competition between players? Think of patience. In ball-games there is winning and losing; but when a child throws his ball at the wall and catches it again, this feature has disappeared. Look at the

> parts played by skill or luck; and at the difference between skill in chess and skill in tennis. Think now of games like ring-a-ring-a-roses; here is the element of amusement, but how many other characteristic features have disappeared! And we can go through the many, many other groups of games in the same way; can see how similarities crop up and disappear.
>
> And the result of this examination is: we see a complicated network of similarities overlapping and criss-crossing: sometimes overall similarities, sometimes similarities of detail"(Wittgenstein, 1953, §66).

The concept 'game' can be applied to a multiplicity, all of which have a number of overlapping elements, but to which we can not seem to find an underlying essence or nature. Wittgenstein famously characterises these similarities as "family resemblances". A number of overlapping features exist between all the things we call games, but there is no underlying single property that all games have in common. Rather, the claim is that there is a multiplicity of elements that hold the concept together, a number of overlapping features, but no single feature that holds for all the things we call games. Does this mean that what ought to count as mental disorder is simply a matter of judging similarity to other mental disorders? This, I will argue, is not the right conclusion to take from Wittgenstein's observations. Rather, that what counts as mental disorder is to be found within the broader contours of the way we live, which involve, for example social, ethical and political norms. In addition, this should make us suspicious of the insistence that there has to be something that ties all the things we call mental disorders together simply because we have the word 'mental disorder'

We saw above that Wakefield critiques Lilienfeld and Marino's approach by arguing that there is no criterion by which to judge similarity if we adopt a 'family resemblance' approach. Of course, Lilienfeld and Marino are not purporting to offer a criterion of mental

disorder, indeed, the point of saying that 'mental disorder' is a Roschian concept for them is to shift the focus of the debate away from trying to find the true (definitive) contours of the concept, to an acknowledgement that what we call mental disorder, what we include in the diagnostic manuals, is going to be a matter of politics just as much as it is going to be one of science. I understand 'politics' here as Aristotle characterised it, "The science of the human good", that "master art" the aim and end of which is the human good (Aristotle, 2009). Lilienfeld and Marino argue that future additions of the *DSM* should

> refrain from classifying psychopathological conditions as either disorders or non-disorders. Instead, the *DSM* should have the more pragmatic goal of providing a compilation of well-validated conditions that are currently deemed to require medical intervention (i.e.,treatment, prevention or both) by mental health professionals (Lilienfeld & Marino, 1995).

Beardsmore argues that questions like 'what do all games have in common?, or indeed, 'what do all mental disorders' have in common are questions that we can not possibly answer because in asking the question in this manner we have failed to give a context to our question. What does he mean by this? Beardsmore argues that abstracted from practice, from a form of life where a concept is used to do something, our question lacks meaning. This is to say, without a context, where we are dealing with such an abstraction, there is no criterion for what would count as a right answer. So, although Wakefield is right when he says that Lilienfeld and Marino give no criteria upon which to judge similarity, this criticism seems to equally apply to his approach. By what criteria do we judge that his analysis is correct? Wakefield suggests that a good conceptual analysis is one that will explain our relatively uncontroversial judgements about what is to count as falling under the concept and what is not. The problem with this is why is it that the true nature of disorder should justify *our*

common judgements? Homosexuality, for example, was once commonly judged to be a mental disorder.

Beardsmore argues that the intuition that moves from the question 'how are we able to apply a single name to a variety of particulars?' to the question 'what do all these particulars have in common?' is faulty, he argues that the second question is *nonsense* (Beardsmore, 1992). Wakefield and Boorse essentially ask 'what do all true mental disorders have in common?'. This is seen as a natural way to investigate what the proper domain of psychiatry ought to be. However, it is unclear that simply because we have a single term for something (mental disorder), that it therefore follows that it is possible to uncover what all the things to which we apply that concept have in common (conceptual analysis). Such an investigation is devoid of any context, and it is precisely because of this that Beardsmore argues one cannot answer a question such as 'what do all games have in common?'.Without a context Beardsmore suggests that we lack a criteria for answering the question. We can see here how the thought that analysing the concept of mental disorder, getting the definition right, discovering its true essence, while an intuitive thought, is in itself quite a problematic project. Wakefield and Boorse assume that there must be an answer to the question 'what is mental disorder' by way of a criterion, which as we saw takes the form for them of the disturbance of a natural function.

Beardsmore offers us an example that helps us understand what he means by the above claim. There is a class of O-level students, a subject based qualification in England, which the teacher has left unattended, and upon return, finds them "engaged in playing chess, an improvised game of cricket, patience, flying paper planes and so on". The teacher then reprimands them for playing games when they should be studying. Beardsmore argues that there is no reason why here we cannot identify a criterion of things in common that the teacher means by the word 'game'. It is all those distractions the students are engaged in that are unrelated to their coming O-level

examinations. The point is that, given a context, if we look at the use of a word in practice where it is being used for a purpose, rather than as an abstraction removed from all contingencies of perspective and context, then it is indeed possible to give, in a sense, an analysis of the word 'game'. That is, give an analysis of the word in terms of a single feature or criterion that all instances of the word, in that particular context, have in common. Of course, this doesn't amount to an analysis in the traditional sense of discovering the contours of the concept in general. Rather, what such an analysis would amount to would simply be a description of the situation, which would explain how the teacher is using the word. Broadly speaking, we would be explaining what the teacher is doing.

The kind of search Wittgenstein asks us to engage in when he asks us, 'what do all games have in common' is precisely a search devoid of context, devoid of a criterion by which to judge an answer.

> It is a search that can only be undertaken if we are willing to abstract from those particular *human interests and purposes* [emphasis added] which give the question whether X is the same as Y, whether X resembles Y, its sense in a particular context. But then, on reflection it is obvious that this must be so. For the original question 'what makes us identify all the things that we call games as *games*?' is itself a mere confusion. For there is no such class as 'all the things that we call games'. People call certain things games for particular purposes and not for others (Beardsmore, 1992, pg142).

People call different things games for different purposes. Beardsmore uses the example of bullfighting. Suppose someone was horrified by the idea of bullfighting, he suggests that we could not expect to convince them that bullfighting was a game by pointing out various relevant commonalities with other games such as the skill involved, or the athleticism and so on. Such resemblances, he suggests, for such a person are irrelevant to the discussion. By calling bull fighting a game

we paint the activity in a certain light. Moral and ethical considerations will come into play as to whether we would consider bull fighting a game. To call it a game has the effect of making light- it could be argued- of the brutal nature of such an activity- 'war is a game'. This is a political question, ought bullfighting to be considered a game? It seems no amount of analysing the concept of game would move such an argument forward. It is important to note that such a debate is not over the intelligibility of calling bull fighting a games (Tessin, 1996). It is not the meaning of the word that will resolve such a debate. And if one were to try to resolve a debate in such a manner, one would, Timothy Tessin suggests, first of all have to come up with an adequate theory of meaning, something he doubts is possible.

Where does this leave our debate over the concept of mental disorder? I believe it throws into doubt the idea that 'conceptual analysis' can get us very far. Both Wakefield and Boorse find it an intuitive question to ask- what is the *real* meaning of the word 'mental disorder', this assumption defines and limits the kind of answer that can be given. A single concept, such as 'game' or 'disorder', can be applied *intelligibly* to a number of disparate instances. The meaning of a word is grounded in our actual use, such that a definition that lays out the meaning will be of little help to answering our question of what ought we to think of as a mental disorder. Again, this becomes a political project, one in which Wakefield and Boorse can, in a sense, be seen as participating. They are making a suggestion about how we ought to be using the concept of mental disorder. They do so by placing severe restriction on what it can be applied to, which as I have claimed, is a direct response to the anti-psychiatry critiques.

In so far as conceptual analysis is an analysis of our linguistic behaviour, it is a description of a practice, an analysis of 'mental disorder' would be more of a sociological investigation into the practice of psychiatry and modern medicine. What are the kind of things we actually call mental disorders? Which could amount to a rather disparate list, in much the same way as a list of all the things we

call games does, or indeed, thinking in terms of a practice, all the things we hit hammers with. An analysis, abstracted from any particular context, 'the crystalline purity of logic' is what Wittgenstein characterised as 'slippery ice', conditions that are perfect for our abstract theorising, but inadequate when we attempt to apply such theories to the real world, hence his advice, 'back to the rough ground' (Wittgenstein, 1953, §107) of what we actually say and do.

If psychiatry is a practice that is not held in check by any objective factors, how is it to be made a rational practice, indeed, how is it to be critiqued at all if there is no independent standard against which to judge it? Naomi Scheman explores the idea of returning to the 'rough' ground', the idea that "what we do is to bring words back from their metaphysical to their everyday use" (Wittgenstein, 1953, §116). She argues that the 'true home' of the concepts we use, are not to be found in the well-ordered purity of the world of logic, but rather in the messiness of our everyday activities. The thrust, for us, being that our philosophical quest (Wakefield, Boorse), becomes non-philosophical (in the traditional analytic sense), that is, becomes openly political. "We can come to identify our sense of dis-ease with what we do as not calling for a repudiation of human practice in favour of something independent of it, but for a change in that practice, a change that begins with a politically conscious placing of ourselves within, but somewhere on the margins of, a form of life" (Scheman, 1996, pg387).

Scheman introduces a film by Harvey Feirstein titled T*orch song trilogy* (1998), and describes a debate that brings out this point. In it, Arnold, a man who is homosexual, and his mother are at a cemetery where both Arnold's father and his lover are buried.

> His mother comes over from her husband's grave to Arnold's at his lover's, furious at what she (correctly) perceives as his sense of commonality in their losses. It is obscene to her that he might take himself to feel anything

> like the grief she feels, to be deeply mourning his lover's death, to have shared with Alan love in the same sense as the love between husband and wife. Significantly, the commonality in their actions is called into question along with the commonality of emotions. Arnold's mother demands to know what he thinks he's doing (he has taken a slip of paper from his pocket and is reading from it the Jewish prayer for the dead); when he replies that he's doing the same as she's doing, she insists he's not: "I'm reciting Kaddish for my husband; you're blaspheming your religion. (Scheman, 1996, pg392).

What Scheman asks here is what would count as a settlement of this dispute, can we say of Arnold that his feelings really are the same as his mother's, that they are both experiencing *real* grief or not?

The parallels with the question we saw Drury asking himself are obvious here. What is a real spiritual or religious experience, and what in reality is the result of a psychiatric condition? Was the man he saw who had lost faith in his vocation as a priest suffering from a mental disorder or was he undergoing a genuine spiritual crisis? What is a genuine spiritual experience? We can hear a critique that echoes the one made of Arnold by his mother, "that's not a true religious experience, they are suffering from a mental disorder".

One avenue Scheman suggests is to follow the thought that there is an 'objective' fact to which words such as 'grief' or 'love' refer to. Here, facts are to be thought of as particular states people can be in. These would be states that we currently cannot fully describe. However, with time and the progression of science, we will, armed with a full (complete) understanding of such notions as grief and love, be able to answer such questions. This, in essence, is the approach both Wakefield and Boorse take to the question we are dealing with in this essay. The second avenue she suggests is a Wittgensteinian one. Here, such a question can only be answered by reference to the background

of context, meaning, and action that gives the concept 'grief' its meaning. It is to be found in the details of what we say and do, in the details of these actions, and what they mean in the context of our lives. The disagreement between Arnold and his mother is about, on this reading, whether or not the pattern of his feelings are the same as that of his mother's in the context of her life married to her husband. This is about what the similarities and differences between the two mean. This avenue sees the answer to the question as intimately tied to our *manner of living*, what we consider important in life, to an ideology and notion of the Good. Here, this is a question that we can answer "only against the background of our beliefs and attitudes about, for example, homosexuality". The meaning of 'grief' is connected to a context and background of understanding, a form of life, and it is only by being informed by that that we can go on and say anything about what the word means and how it ought to be used (Scheman, 1996). We can see here why with the second avenue the shift has moved from a philosophical or scientific investigation, to a social or political one. The answer is informed by, and has consequences for, how we live.

What does critique of a practice now look like? In what sense can we get something 'right'? What counts as right? Indeed, what would count as the right application of the picture of mental disorder if there is no standard independent of our actual practice involving social, political and ethical norms? Are we just left with relativism (the comparison of different ways of doing things against one another), having left behind any hope for objectivism (the connection of our practice to an independent order)?

Scheman argues that critique of a practice comes about through the disruption of the taken for granted consensus that how 'we' do things is the right and only way to do things- the anti-psychiatry movement can be seen as doing this for the psychiatric profession. But how does this disruption occur? Being part of a form of life is knowing how to do things around here. A problem arises for the idea of a critique of

how we do things, our own shared judgements and practices, the 'ground' on which we stand which makes what we say and do intelligible. The thought is that we are either part of a form of life, a way of doing things, in which case we are undermining our own intelligibility, or, on the other hand, we are alien to a form of life, in which case any critique we make would be 'off the mark', our critique would lack intelligibility. Scheman draws on Stanly Cavell's 'Manichean' reading of Wittgenstein that sees a form of life as internally homogeneous. One is either inside a form of life, this is simply what "we" do, or one is outside it, in which case one is clueless. One response to this is to say there is an order independent of what we do to which we can appeal- such as the notion of 'natural psychological function'. This is to accept a strict dichotomy between relativism, the Manichean position, and objectivism, the independent order position. Scheman argues that the manichean reading is wrong, there is a third position. That of marginality within a practice.

It is such marginality that provides critical ground- people on the borders of mainstream understandings of the good life, and indeed, many people who are diagnosed with psychiatric conditions occupy such places of marginality. Arnold in the film occupies such a position. "The epistemic resources of variously marginal subject positions provide the ground for a critique of "what we do" that rejects both the possibility of transcending human practice and the fatalism of being determined by it" (Scheman, 1996, pg387). Scheman suggests that realism (attending fully to the reality of what is going on), involves paying attention to what people are saying '*over there'*. Dr Freidirich Truby King, superintendent of Seacliff 1889-1920, an asylum that was located just north of Dunedin, New Zealand, when taking a photo of a Seacliff patient, a 44 year old married women, was told by her "I suppose you want a picture of a mad women. I'd better stick some straw in my hair and make faces" (Holloway, 2001).

This resonates with the critique of psychiatry that it can potentially ignore or silence what someone in a vulnerable or marginal position is

trying to say, the idea that 'mental disorder' renders the meaning making of someone completely chaotic or deficient. The voice that can't be heard. If Tolstoy was suffering from clinical depression, then we might be inclined to think that what he had to say was of less value-"he was just depressed", or another famous example, Schopenhauer's famously pessimistic philosophy could be put down to clinical depression. Of course, we are also inclined to believe that what one says ought to stand or fall on its own merits, regardless of the person's state of mind. This may be the case, but a prejudice exists that is inclined to disregard the "ravings of a lunatic".

We can now see that 'mental disorder' can be applied to a number of particulars while having no general over arching essence. The question is not what can 'mental disorder be *intelligibly* applied to (although this will tell us something- namely about our current practices, values and so on), but what ought we apply it to (a political question). Scheman tells us there is no 'home' for our words apart from the ones we give them, or create through our practices that are as varied and messy as life itself. Of course we do have to be careful, it is important to remember that our practices take place in the real world. There is a danger of engendering a picture of human practice as a free floating arena that is unconnected to the world. Our practices of course do engage with the world. Physics, the paradigm of the sciences, is not something that is an insulated realm of speculative human thought. There is such a thing as 'getting it right'. Physics deals with the physical world. Boorse and Wakefield attempt to model psychiatry on such a paradigm, conceptualising the domain of psychiatry as a natural fact. I argued in the previous chapter that this approach doesn't work for the concept of mental disorder. The concept is intimately linked with social, ethical, and political norms, with how we live. The comparative 'messiness' of psychiatry has to do with its subject matter. The homes we create for our words relating to psychiatry are messier than physics because they are placed in a practice that deals with, engages with, and assists in, human life.

The answer to our question, 'what is mental disorder?' is, echoing Drury, intimately connected to our manner of life with all of its attendant ethical, political and social connections. The question itself is, in a sense, a meaningful question. It is just that the answer we give to that question may not help us much in answering in a final and definitive manner questions such as the one Drury poses. The practice of psychiatry is not defined by anything supra, or beyond the particular details of the practice itself, and how those connect with, and are formed through, the wider context in which it occurs. This is to accept whole heartedly that psychiatry is a practice that is shot through with values. Accepting this means that we ought to openly acknowledge this in our debates about what ought to be considered for psychiatric treatment, when such treatment is appropriate and so on.

4.4 What to make of our question with Wittgenstein in mind: some tentative conclusions

Just as the question of whether or not Arnold and his mother were both experiencing *real grief* is a matter of what those terms mean in the weave of our existence (our form of life), the background of context and activity that makes such terms intelligible within a community, so too is the question Drury asked as a psychiatrist. The answer will be informed by, but as I argued above, not blindly determined by, our form of life. A form of life isn't simply homogeneous, an agreement about everything. Disputes as to what we ought to be doing do occur. The debates surrounding, and the subsequent removal of, homosexuality from the DSM exemplify this. The claim here is that disputes regarding the proper domain of psychiatry aren't settled by reference to a point outside, or independent of, our form of life. To return to a claim I made earlier, good psychiatry comes about not from discovering such an Archimedean point, but rather from developing a richer understanding of the contours and context of its own practice, that is, attending fully to how it is that our own way of living is so tied to judgements involved in

mental health care.

On this interpretation of what conceptual analysis and critique amounts to, both Wakefield and Boorse can be seen as offering suggestions about how the concept of mental disorder ought to be used. The concept ought to be completely independent of any socially informed notion of the Good. We saw how Wakefield and Boorse, with this in mind, attempted to suggest an understanding of mental disorder that was fundamentally chaotic, a complete absence of order- there is no conceivable point to the way someone is behaving. This is understood as the breakdown of a natural psychological function. The suggestion here, on a Wittgensteinian reading of their project, is that it is an ethical/political suggestion to the effect that psychiatry ought only to be concerned with conditions that are like this. There are 'oughts' in their theories, they just come in in an oblique manner. The claim here is that they are making a political or cultural claim about what the practice of psychiatry ought to be about. The notions of authenticity- one ought to live life in a manner that rings true to ones own self (the Good is at least in part relative to what I consider it to be), and the Millian principle of liberty that one ought to be free to do as one pleases as long as one does no harm to others- in particular both physical and moral harm to oneself do not count as reason for interference by the state, both, I would suggest, motivate there respective projects.

This is a political claim about what we ought to think of as medical conditions. Something that of course depends on what it means to call something a medical condition- the worry of the anti-psychiatry movement was in a sense, as I have attempted to argue, congruent with those of naturalists such as Boorse and Wakefield. The principal concern is that the application of medical representations to someone's problem with living potentially silences someone's attempt to live life in a particular manner, and thus is contradictory to both our ideal of authenticity and the principle of liberty. I have argued that both Wakefield's and Boorse's attempts fail to strip mental disorder of

social, political and ethical connections, and in the current chapter I have explained why such an attempt as theirs is not necessarily the only way forward. I have traced Bolton's thought that our understanding of what mental disorder is has changed, mainly under the influence of the cognitive psychology paradigm, such that what it means to call a condition a medical condition has changed. That is the medical picture that openly accepts that the kind of things people see psychiatrists for often do have a point to them, allaying to a certain extent the fears of the anti-psychiatry critique that we may label ununderstandable what is in fact understandable.

What is distinctive about psychiatry is the kind of response it makes to people's problems, rather than the nature as such of the problems it deals with. This means that borderline disputes as to whether there is a need to treat or not are inevitable and not easily answered. What then is the proper domain of psychiatry? According to Bolton, "the proper domain of medicine and of healthcare generally is construal of suffering as being [as] such, and attending to it on the basis of professional ethics, training, clinical experience, and the available science of causes and cures" (Bolton, 2008, pg198). Psychiatry attempts to relieve the suffering of *someone*- the emphasis is to convey the moral insight that in medicine one is not simply dealing with disease entities, one is engaging with people. Something that Bolton suggests is roughly the stance taken by the DSM, where the disorders compiled are roughly decided upon by their association with distress or disability, the risk of adverse outcomes, and the additional criteria that the problem is a matter of personal dysfunction, and is not just a matter of deviance from the social order. The clinical expertise and sensibilities required to carry this out in a manner that successfully tracks both the truth of the situation, and the Good, are both, to a large degree a matter of praxis just as much as they are a matter of scientific knowledge, that is, they are not something that can be simply reduced to a theoretical formula (Wakefield/Boorse) about what ought to be treated and what ought not to be.

Conclusions

We began with the question of how to define mental disorder so as to provide an answer to Drury's question regarding how to separate definitively madness from religion. Thomas Szasz's response to this question would be to claim that our question cannot be answered, not because the dividing line between mental disorder and health is inherently messy, but rather, because the whole notion of mental disorder or illness is a myth. To apply the kind of representations used in medicine, which are according to Szasz inherently value or ideologically neutral, to people's psyche is merely metaphorical, and as a metaphor, it fails to grasp what is really going on in mental disorder. Szasz's critique is of a particular picture of mental disorder, one which he was quite right in rejecting. However, although medicine as Szasz construes it is indeed inadequate for addressing someone's psyche or soul, medicine is not confined to the kind of enterprise Szasz appears to restrict it too. Medicine employing representations involving processes and functional pictures which is also sensitive to social influences and interpretations can, I claim, be the basis for helping someone.

Throughout this essay I have argued that mental disorder is a value laden enterprise, inherently employing a notion of the Good. Boorse and Wakefield argue however that psychiatry is better thought of as a value free scientific enterprise. This is in a sense an attempt to defend the traditional medical picture of mental disorder that is understood as a *complete/total* understanding of the patient's problem, that is, what divides people onto either side of the asylum walls of yore. Mental disorder is understood by Wakefield and Boorse as a biological fact in the form of the breakdown of natural psychological functions and processes. The chief difficulty of the accounts given by both Wakefield and Boorse is that of trying to define natural functions of the human psyche against which the pathological can be defined. However, with the closure of the asylums and the shift to community

care, the division between the mentally ill and the rest of the population has relaxed. This has in a sense mitigated the need for such a strong dividing line to be drawn. Rather than worrying about putting people on the wrong side of such a dividing line, I have argued that mental disorder should not represent to us a separate world, one completely removed from the world of reason, truth and goodness. The question of 'madness or religion?' does not admit of a definite answer either way.

A traditional philosophical response to the question over the proper domain of psychiatry is to look for a definitive definition of mental disorder. One analyses the concept of mental disorder so as to come up with strict criteria for the application of the concept that will clear up all the grey areas of psychopathology, turning it into a true science. However, in much the same way that analysing the concept of 'grief' would not help one settle the dispute over whether Arnold's mother's grief for her Husband's death was of a similar nature to that of Arnold's grief over the death of his homosexual lover, so too analysing the concept of 'mental disorder' will not help one tell whether the priest who came to Drury was suffering from a medical condition or was rather undergoing a profound spiritual experience. The answer given will, as Drury suggested, be informed by and reflect our own manner of life.

Derek Bolton has suggested that Psychiatry is defined by a particular way of understanding people's problems, rather than by the nature of the problems themselves. This too mitigates the need for a hard and fast distinction between what we ought to consider mentally disordered and what ought rightly to be considered other kinds of problems, moral, social or political for example. One of the chief motivations of the anti-psychiatry critiques and of the attempts to offer a definitive definition of mental disorder is the thought that the label of mental disorder represents a complete disintegration of the

personality, rendering the sufferer sub-human and therefore not a full member of the world of truth and goodness. However, such an understanding of mental disorder, although as Drury points out, a common prejudice, it is not the reality of mental disorder. Many of the problems that people come to psychiatrists with are also moral, social, spiritual and ethical problems. Psychiatry represents one form of understanding and healing amongst others, psychiatry as representing a 'provisional truth'. The question is not therefore is this a genuine disorder or rather an imposition of values, but rather, is the medical response appropriate here, is there a need for treatment? Something that rests on a range of clinical judgements to do with context, harm caused to the individual, an understanding of normal (socially informed) behaviours, and beliefs, as well as a sensitivity to difference, diversity, and social or cultural interpretation.

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