Mental Disorder as a Practical Psychiatric Kind

Brian O'Connor (University College Dublin)

Abstract

This paper proposes that mental disorders are best conceived as practical psychiatric kinds. This means understanding them as the products of psychiatric practice. The practical psychiatric kinds approach emphasizes the fundamentally normative rather than natural structure of mental disorders. The paper critically considers an earlier biologically oriented effort to eliminate categories of mental disorder. It also assesses efforts both to take a "balanced view" of mental disorders as equally causal and social kinds and to retain categories of mental disorder by finding the right supporting natural kinds based theory. These assessments lead to the contention that psychiatric kinds are practical, geared toward successful living and oriented towards individuated needs. The practical psychiatric kinds thesis provides an alternative way of entering into a social critical evaluation of the normative dimension of mental disorders today.

keywords: classification, distress, normativity, practical kinds, psychiatric kinds, social impairment

The are different ways of responding to the absence of a shared physical causal core among the range of mental disorders currently recognized by the *International Statistical Classification of Diseases and Related Health Problems* (ICD) and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Obviously enough, some of the listed disorders are not physically explicable in principle, while others are merely likely to be biological in origin. Only a minority of disorders can be explained as the outcomes of impaired biological function, and in some of those cases biological explanations capture their phenomena little more than partially. Psychiatry nevertheless is perceived as and understands itself to be a scientific enterprise. Its diagnostic manuals are conceptualizations of certain sorts of human behavior as distinguishable and apparently rule-governed processes. These processes are in some

* 'Mental Disorder as a Practical Psychiatric Kind', *Philosophy, Psychiatry & Psychology*, Vol. 24.4 (2017)

way thought to be grounded in nature. They are in that respect conceived of as "natural kinds," objective states of affairs whose ontology is independent of norm or convention. Their status as "disorder," however, is a matter for psychiatric work guided by the question of whether those entities have consequences for our mental, emotional or behavioral well-being. The purpose of taxonomy in this domain is to plot out a map of experiences and behaviors considered to be abnormal in specified ways. Practitioners are given a vocabulary with which to capture and communicate, especially to other practitioners, their observations of people who arrive at their clinics. That vocabulary often leaks out into wider society and influences non-professional perceptions of abnormality. Psychiatry itself, though, is influenced in its turn by social values, a point that will be significant to the main claim of this paper. Once those abnormalities are established as types known as "mental disorders" there is the further effort to identify standard treatments.

Each new edition of the diagnostic manuals – the DSM especially – is received with dismay about its ever increasing size.[1] Questions are raised about the huge number of listed disorders, about the encroachment of medicalization, and about the very status of psychiatry as a science when what interests it is subject to endless thinly justified revision and so much of which is without biological explanation. That last issue is of central significance to this paper. The expansion of listed categories, it seems to me, can be met with three broad theoretical possible responses (with numerous variations on each): (1) *eliminate* where science is absent, (2) *retain* by developing a sympathetic new science of disorder, (3) *elucidate* on non-scientific grounds. This essay adopts the third position. The proposal on offer is that we elucidate the categories of mental disorders as *practical psychiatric kinds*. This means understanding them as the products of psychiatric practice. This view is in direct opposition to the theory that mental disorders are natural kinds. It does not deny that pathological conditions give rise to certain types of mental, emotional or cognitive disturbances. What it specifically rejects is that "nature" plays an authoritative role in determining what counts as a mental disorder. There are exceptions. The cognitive and emotional difficulties that result from degenerative dementias are obviously physical in origin, and identification of the causal factors can provide substantial etiological differentiations between its diverse forms. It is plausibly the case that the various categories of neurocognitive disorders are natural kinds which reliably give

rise to symptoms which are of interest to psychiatry. Mental disorders are, otherwise, normative categories whose validity is dependent on psychiatrically autonomous processes of diagnosis. The autonomous processes of justification are delimited by what the practice of psychiatry counts as a good reason. Practical psychiatric kinds, then, are not determined by the thesis that mental disorders are the manifestation of an underlying natural dysfunction, or at least one that could be identified without reference to psychiatric norms. Mental disorders are phenomena that are developed within the institution of psychiatric work. That institution has an interest in restoring personal functioning, whether or not the impairment stems from natural kinds dysfunction. This points to, as Owen Whooley rightly notes, a tension "between psychiatric clinicians and researchers" (Whooley, in Phillips et al. 2012c, 3). The diagnostic manuals are "produced by psychiatric researchers, who are attuned to different goals (e.g. reliability, standardization, robust research designs, and statistical analyses) than the average clinician" (Whooley, in Phillips et al. 2012c, 3). The manuals should reflect clinical work. However they are too often perceived – not least by philosophers – as the quintessence of psychiatry. The domain of psychiatry is then understood as what is encompassed in the manuals. Closed off from the clinic theoreticians take the listed categories as delimitable types: they reify those categories and then look for their objective conditions. The favored natural kinds approach is to believe that, even if only in principle, science can establish the characteristics of the material which psychiatrists may then use in their clinical work.

Elimination

The first response to the growth of diagnostic categories might be to insist on a transparent science of some sort which could ground mental disorder. Once the parameters of what counts as "real" are established science can police psychiatry, and, where necessary, eliminate those categories of disorder for which we cannot hope to find the support of that science. We would then, as a consequence, de-medicalize behavior previously understood to be of psychiatric concern. The most prominent proponent of this thesis is obviously Thomas Szasz. Its icy simplicity has had none of its desired results. We might infer that its failure to influence the course of psychiatry suggests that it rests on a misconception of what psychiatric practice actually is. (Though the self-understanding of mid-twentieth century psychiatry may not match that of today.) Szasz argues that a disorder is either a brain disorder or it is simply a

"problem in living" and not a mental disorder as such (Szasz 1960, 113 et passim). Disorders, effectively, are to be released back into the wild and individuals can take possession of their personal problems with an heroic existentialism. Medicalization has tended to relieve them of that responsibility by identifying the problem at issue along the lines of a disease or illness adventitious to the individual's will. Szasz's beguilingly deflationist language – problems in living – has not, however, done the work of deflating the phenomenon. The prevailing view – or obdurate intuition – is that there is something like a state of having a mental disorder. That state, this view holds, cannot be translated without remainder into a drama of personal misfortune. In short, from the point of view of a society in which categories of mental disorder have entered not only our language but also our ways of understanding what it means to be a human being a proposal for wholesale elimination of those categories is unlikely to be well received. Were psychiatry applied biology Szasz might indeed have a case. However, it seems clear that psychiatry is – today at least – not reducibly a branch of that science. Much more than the treatment of even putative organic disorder is, as we shall see, demanded of it.

Retention 1: The Balanced View

Retention, in its various forms, adopts some version of the "balanced view." That is the cautious proposal that mental disorders are a mixture of both "natural kinds" dysfunction and "social kinds" contextualism. There is some type of causal process at work in disordered behavior, as Jonathan Glover, a representative example of this view, insists (Glover 2013, 294). On the softer end are positions like Allan Horwitz's, which holds that valid "definitions of mental disorder… contain both a universal quality that refers to internal dysfunctions and a culturally specific quality that defines what conditions are inappropriate in particular contexts" (Horwitz 2002, 26). And even conceding that a great deal of what constitutes a mental disorder is social construction he nevertheless insists that "something is being constructed" (Horwitz 2002, 229). This view, one might think, should be able to make good on the reality of that underlying "something," some intuited given or whatever it is. This it does not do, however (although Jerome Wakefield's controversial theory of evolutionarily grounded harmful dysfunction is cited in support[2]). There is nothing particularly unusual in the move made by Horwitz. It is part of the balanced view to assume that there is an implicit scientifically valid dimension – an objective non-psychiatry

specific dysfunction or failure – to mental disorder, even where limited evidence in support of that assumption can be readily presented for anything other than a few cases. Nothing that is said here excludes the possibility that ongoing biological research into mental disorders might deepen our understanding of causes and treatment and that the number of mental disorders that gain biological grounding might increase. What is at issue, however, is whether that research clarifies the practice of psychiatry itself.

Retention 2: Mental Disorders as Kinds-in-Science

More ambitious versions of the balanced view go in search of direct justification of the natural kinds side of the mental disorder complex. This not only gives the idea of mental disorder the theory it has previously only been promised, but it also comes with the prospect of establishing psychiatry as the proper science many would like it to be. We can see a powerful example of this in Rachel Cooper's effort to reconceive natural kinds in ways that are sympathetic to psychiatric objectives. Her approach is, in effect, to find examples of acknowledged natural kinds and to show, contrary to the common view, that these natural kinds share relevant characteristics with natural kinds in psychiatry. This is a generous rather than eliminative project, its basic program supportive of psychiatry. Its practical outcome is the retention of psychiatric categories on a new, incontrovertible basis akin to the objectivity of the periodic table for chemistry (Cooper 2013, 950).

Cooper is specifically interested in providing this grounding through a "kinds-in-science" conception of natural kinds. Classification in the kinds-in-science tradition, she claims, is not to be confused with the search for essential properties. (Does this complicate the parallel with the elements in the periodic table?) This form of classification is evident in the case of "members of a species" that "can be expected to behave in similar ways" in spite of diversity "at both the genetic and phenotypic level" (Cooper 2013, 952-3). Classification in this field "can successfully ground explanations and inductive inferences even though members of the species do not share the same essential property" (Cooper 2013, 953). To avoid an essentialist misunderstanding of Cooper's claim we need to see what constitutes a species classification: a cluster of properties whose clustering underpins the characteristic behaviors of a group. After considering a number of analogies between

uncontroversially accepted natural kinds and categories of mental disorder she notes: "My kinds need not have essential properties, can vary along continua, and can be historically contingent, in fact they may arise only along certain historical conditions. The reason I think it's reasonable to call such kinds natural kinds is that they are up to the job of grounding explanations and predictions" (Cooper 2013, 957).

Linking this specifically with psychiatric research she writes:

> Though they may not describe their aims in these terms, I take it that research programs such as that associated with the DSM aim at discovering natural kinds of mental disorder. A basic assumption of the DSM project is that discovering kinds of mental disorder will be important for grounding psychiatric theory. (Cooper 2013, 960)

It is not clear that the DSM or the ICD are Mendeleevian enterprises. One might instead see them as digests of ongoing clinical experience. They provide psychiatric practice with convenient but not authoritative abstractions, all of which are revisable in principle. What is characteristic of a theory-first approach like Cooper's is its hunch or its hope that the complex range of mental disorders, so many of which present in diverse ways and are diagnosed with entirely different considerations in mind, might be reducible to a natural kinds framework. This looks to be suppositive. It determines what the proper basis of psychiatric material is *as though* this basis was implicit all along.

A more tentative form of retention based on kinds-in-science analysis exists. This is the view that mental disorders are natural kinds in principle. Helen Beebee and Nigel Sabbarton-Leary hold that "there are good reasons to think that some or all of the categories *currently* recognised by psychiatry are not natural kinds because we have good reasons to think that a significant amount of reclassification will occur in the future, on the basis of additional evidence, new treatments, and so on" (Beebee and Sabbarton-Leary 2012, 12). Natural kinds conceptualizations are given authority in what will determine the sphere of clinical work. This opens up the brave prospect that much of what is taken by psychiatrists to be real will be exposed in the future as false once natural kinds oriented research into the categories reaches some new level of

sophistication. But this imaginative ideal does not help us to understand current practices in psychiatry, which continue to drive onwards in the absence of a better science.

What is it in principle that psychiatry would be helped with through this natural kinds grounding? Cooper, as we have seen, believes that "natural kinds" in this context can ground "explanations and predictions." It is certainly true that psychiatrists seek to pattern their patients' behaviors, and a number of pre-existing patterns – designated mental disorders – are institutionally supplied. However, the treatment of disorder owes surprisingly little to the manuals, and the patterns they form tend to be highly particular. Psychiatrists frequently make imprecise and conflicting assessments of their patients, but not because they cannot quite find the right applicable category. Rather, they are challenged by the task of coming to know the patient's actual needs. A patient's need is sometimes that of getting over a crippling psychological disorder. But often the need is related to addressing a way of life, a terrible experience or an ongoing failure to succeed in basic ways. These considerations are not ancillary to the core disorder: *they are the disorder*, in spite of abstract characterizations of the patient. Treatment is patient specific, and sometimes not specific enough. As Allen Frances puts it: "The definitions of mental disorder offered here make perfect sense in the abstract, but provide no guidance on how to make concrete decisions" (Frances, in Phillips et al 2012a, 25).

With this in mind, it is arguably an irrelevance to try to articulate the particularity of patients' disordered experiences as grounded in natural kinds.[3] A misunderstanding of this primacy-of-the-practical approach on this point is that it seeks to undermine the value of the diagnostic manuals. After all, the analysis maintains that the sensitive clinician moves irreversibly from the general – a range of possible relevant disorders – to the particular, the individual patient whose situation is ultimately irreducible to generalities. The editors of the DSM are conscious of the limitation of the manual as a clinical tool, recognizing that "it is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder diagnosis" (APA 2013, 19). There is no reason, though, to see the manuals as standing in conflict with practice once they are employed as heuristic tools, giving some sort of initial frame to the reported and observed experiences. However, there are numerous types of psychiatrists, ranging

from those who find epistemic and professional security in their manuals to those psychotherapeutically inclined clinicians for whom psychiatric language itself is perceived as a limitation.[4] Philosophers who wish to defend the natural kinds theory of mental disorder probably have the former group in mind, conceiving psychiatry as a discipline which strives for the same diagnostic clarity and detachment as found in other branches of medicine.

This paper, then, is proposing that our understanding of psychiatry is misguided when we attempt to align its work with any kind of scientific research project geared towards the establishment mental disorders as grounded in nature. This is perhaps to be expected with a sideways on, rather than practical, view point. We can highlight the point by looking at an attempt to eliminate a specific mental disorder which is not supposedly properly scientific. Louis Charland argues "that the conditions we now call 'personality disorders' actually constitute two very different kinds of theoretical entities. In particular, several core personality disorders are actually really moral, and not medical, conditions. Accordingly, the categories that are held to represent them are really moral, and not medical, theoretical kinds" (Charland 2004, 64). He shows that the descriptive terms applied in DSM IV to "cluster B" type personality disorders – antisocial, borderline, histrionic, and narcissistic – differ from those in the two other clusters. The terms in question are laden with moral evaluation. This is, he thinks, an obvious error for the enterprise of psychiatry. "Terms with strong or even weak moral or evaluative connotations," he writes, "are to be avoided as much as possible" (Charland 2004, 70). And this is because psychiatry "is part of medicine, and medicine is supposed to be based on science" (Charland 2004, 70). This cry for secure foundations that are indifferent to what psychiatric practice actually does leads him to a narrow view of the clinic. He believes that the "point is to identify and describe mental categories and conditions that are of 'clinical' relevance, not to morally evaluate those conditions and the persons who suffer from them" (Charland 2004, 70). The personality disorders he wants to delete from the list are, he thinks, the products of plain moral disapproval. There is indeed widespread distaste for some of the characteristics associated with those disorders. It is curious, though, that very little of what is morally objectionable has become a topic for psychiatry: bad manners, greed, ingrained biases, insensitivity, for example. We need to think more about what marks out the cluster B personality disorders. Certainly they are not "genuine natural disease

entities" (Charland 2004, 72). But Charland is open to question when he holds that these disorders are not of clinical relevance. The personality disorders in question are constructs of a certain kind. Nevertheless, they encompass ways of behaving which are persistent and disadvantageous for the individual. The possibility of emotional success is impaired by that behavior. This, in psychiatric practice, is sufficient to give them practical weight. It is unlikely, for that reason, that criticisms along Charland's line will do anything to change the status of cluster B personality disorders as a variety of mental disorders. They are, in certain respects, practical psychiatric kinds par excellence in that their conceptualization owes nothing to a scientific or naturalistic theory about their emergence or cause (notwithstanding highly conjectural back stories about development).

Retention 3: Zachar's Practical Kinds

A contrast with Peter Zachar's notion of mental disorder as a "practical kind" might help to clarify further the claims distinctive to the "practical psychiatric kind" view proposed in this paper. Zachar does not regard practical kinds as specific to psychiatry. His project is to reveal the dependence across various scientific enterprises of what should be conceived properly as "practical kinds" rather than "natural kinds." The latter, he holds, are generally assumed to be some sort of entity that can take the form of a "bounded" category whose reality is "independent of any particular way that we may conceptualize it" (Zachar 2000a, 168). Natural kinds, in this regard, "are supposed to be true in all possible worlds" (Zachar 2000b, 191). The anti-essentialist view Zachar defends applies to all disorders of interest to medicine: "Because phenomena such as diseases and species (as currently understood) are not natural kinds, mental health professionals should not think of psychiatric disorders as natural kinds either" (Zachar 2000a, 168). His anti-essentialist view is a pragmatist one which offers an explanation of the working usefulness of our categorial determinations.[5] Those determinations cannot hope to have perfect reliability, given the complexity of the world they are trying to organize (Zachar 2000a, 170). Zachar's project then is, as he describes it, "a general theory of scientific classification… a nonessentialistic theory" (Zachar 2002, 119). Interestingly, Zachar places this theory within what, in this paper, I have called "the balanced view." He thinks that the "practical kinds model does not deny that things have internal structures; it only denies that internal structure by itself determines category membership" (Zachar 2002, 119).

The notion of practical psychiatric kinds proposed in this paper and Zachar's notion of practical kinds are not in direct opposition. They are both, though in differing respects, anti-essentialist but they also, I believe, have divergent ends. As just noted Zachar is attempting a new theory of scientific categorization. Zachar aligns his pragmatic version of practical kinds with three propositions from George Lakoff. The second of these is most significant for the contrast between our positions: "The world is somehow the cause of our knowledge" (Lakoff, quoted in Zachar 2002, 170). What I am emphasizing in the notion of a practical psychiatric kind is the manner in which the very notion of disorder is justified within psychiatric practice. That justification is autonomous in the sense that nature understood as some kind of external authority is in no meaningful sense – perhaps informally and non-technically – the cause of our knowledge. In that context the diagnostic categories provide a purely provisional entry into a conscientiously developed clinical assessment. Certainly, the categories are "useful," but what is of real practical significance is whether or not work within the psychiatric context is persuasive. (I have already noted some of the conditions of what makes a diagnosis persuasive are influenced by the broader social normativity within which psychiatry essentially operates. More will be said on this point below.) In that context what many would like to think of as ordinary unhappiness or nervousness or problems in living may become matters of concern within the clinic. Researchers may try to rein in this expansion by looking for structures, essences, invariant patterns, statistical constancy or whatever. But until such time as psychiatry develops a stringent and austere set of disorders psychiatric reality will be a matter for psychiatric work. Zachar's theory, by contrast, is directed towards the conceptual substance of the formal categories, not the conduct of psychiatric diagnosis and its relation to categories of disorder.

Elucidation – Practical Psychiatric Kinds

In the text above a number of claims have been made:

• the realm of mental disorder does not seem to be governed by biology;

• the realm of mental disorder continues to expand without strong causal evidence for its many categories;

• to accept as mental disorder only what is admissible on independent scientific ground is, however, counter-cultural (the case of Szasz).

Alongside these claims there are a few obvious ones we need to accommodate if we are to make sense of psychiatry as it stands:

•• psychiatry without a scientific form – an interest in, for instance, stable generalizations based on clinical experience – is institutionally unacceptable: its determinations could become a series of novel and unrepeatable descriptions;

•• it would be unacceptable to itself since it understands its own endeavors to have an independently objective topic: mental disorder;

•• psychiatry takes seriously the idea that there is suffering which cannot be translated adequately into "problems in living."

These six claims can work coherently together if psychiatry, as I propose, is interpreted as a *sui generis* practice. Earlier, the obvious exception of the neurocognitive disorders were noted. Outside these kinds of diseases, however, the psychiatric use of biology may be viewed as partial and non-binding. Dysfunction grounded a step down from psychiatry itself is of no decisive importance in determining which behavior is disordered and which is not. This may indeed explain the tremendous expansion in the list of categories: the list is not constrained by the kind of empirical research that can establish causal conditions. This does not, however, explain why it does actually grow. I want, in this section, to offer some ideas to elucidate why this growth takes place, why it is consistent with current psychiatric culture, and, why it is also sufficiently scientific – in a very specific sense – to allow psychiatry to maintain its scientific demeanor.

Elucidation 1: the Social Dimension

The most recent three editions of the DSM – 1980, 1994 and 2013 respectively – have ventured an overarching definition of mental disorder. To date no definition has been offered by the ICD. There is only minor variation across the three confidently succinct iterations. The current DSM states:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually

> associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (APA 2013, 20).

The social context of disorder, then, is frankly acknowledged, though without any claim that the disorders are social in kind. Rather, social context is the occasion rather than a property of the disorder. We might push this point a little, though. The text intends that a "disorder is a condition of a person, not of his environment" (Gert and Culver 2004, 422). This does not preclude allowing that some social arrangements lead to increased instances of some disorders. It may be interesting that, for example, high levels of unemployment correlate in some places with certain levels of clinical depression. However, unemployment is not supposed, in the official view, to be identified as the cause: the depression is, rather, a pathology of the sufferer. The assumption here is that there is a rather straightforward way of delineating what is inside and what is outside the individual. Society is outside, according to this point of view. But socialization, plausibly, means more than a capacity to know what it is to act appropriately. It really means acting appropriately, without having a fully transparent relationship to that acting. For this reason, when we think of mental disorder as evidenced by "significant distress or disability in social, occupational, or other important activities" we need to recognize how a capacity for some level of success in all of these spheres is a value which cannot be clearly divided along inside/outside delineations. What is distressing, in short, is impairment in fundamental human modes, *whatever we – socialized and socially responsive beings – take them to be*. And it is in relation to that distress that psychiatry is sought out either by individuals who are suffering or by others with a paternal interest in individuals who may not agree that they bear a deficit.

Elucidation 2: The Priority of Practice

If psychiatry is the practice of determining on psychiatric grounds where a disorder is present and how it must be addressed mental disorder is, ultimately, what psychiatrists

believe, through the norms of their profession, to be a disorder. That profession is primarily receptive to the evidence provided in the clinic rather than the "natural kinds" theorizing that comes from outside it (with a few notable exceptions). In this regard it is consistent with psychiatric practice to understand disorders instead as practical psychiatric kinds. This might not seem terribly helpful from the point of view of theoretical enquiry. It appears to evade the question of what a mental disorder really is as opposed to what psychiatry thinks it is. George Graham, for instance, holds that no "concept of mental disorder other than that proposed by or presupposing a good theory of mental disorder suffices as a good concept. A concept with rectitude" (Graham 2010, 20).[6] The standard approach, however, involves bringing preconceived notions of what should count as a good explanation of disorder as though disorder could be demarcated along familiar naturalistic lines. The work of psychiatrists might sometimes be reconstructed ex post facto into neat patterns. Diagnoses are, however, contingent on ongoing experiences, infused with ever changing ideas of what it means to lead a normal life. Psychiatric categories are the products of this practical experience.

A practical psychiatric kinds approach might help us to appreciate why the extraordinary range of disorders stand alongside each other in some sense that seems coherent to psychiatry itself. This is important since, from other perspectives, that coherence is absent. Another way of highlighting what I am proposing here is to contrast it with Nick Haslam's theory "in favor of a pluralist position, according to which the diversity of psychiatric categories is not reducible to a single model. Practical kinds are, I suggest, just one of several kinds of kinds" (Haslam 2002, 204). He convincingly shows that a diverse range of conceptualizations stand behind different forms of mental disorder. But what the practical psychiatric kinds elucidation I propose entails is that those conceptualizations are reconstructions after the fact. What is interesting is what in the end turns certain disturbances into mental disorder. Ultimately it is the outcome of psychiatric practice. Theoreticians then may undertake the edifying but secondary work of linking the categories with whatever kinds are found in the philosophy of science literature. In any case, a pluralism produced after the fact cannot explain the practical coherence psychiatry claims for itself. Or, again to contrast, the thought that we might sometimes allow some exceptions to the general rule that mental disorders are natural kinds operates at the

level of theory in which nature is a gate-keeper. It passes over the vast range of disorders and clinical diagnoses that do not meet this extra-psychiatric standard. This standard is one that, in some respects, cuts the ground from under the idea of a practical psychiatric kind by setting it in a relation of dependence on natural kinds.[7] It seems determined to theorize in abstraction from the clinical situation in which the justification of diagnostic categories is exclusively tied to the patient and not the science lying putatively in the background. The intra-practical coherence of psychiatry cannot be based on natural kinds properties that are independent of those of the practice of psychiatry. The practical nature of psychiatric work is to relieve individuals of mental and emotional suffering. Where there is good clinical practice this involves responding to the patient with due but not decisive regard to the established disorders. This is a broadly moral purpose: to help those with emotional or psychological impairments who appear unable to help themselves. The constraints of natural theories of dysfunction or of biological causality serve a limited role in what is considered appropriate for intervention. (That role is evident in decisions about medication, given its effects on the body.)

Elucidation 3: Psychiatry and Values

Psychiatry's moral purpose cuts across questions of the developmental, organic or circumstantial origins of the suffering. And it is equally permissive with regards to the phenomenological aspects of helpless suffering. As a social enterprise it is not closed off from the changes in moral concepts that take place in the world. The eventual excision of homosexuality from the list of disorders might be explained not as a result of better science but as the result of the growing moral outrage at this negative conceptualization among the wider community. This is not psychiatry giving in to social pressures: it is a reflection of that institution's social situatedness. The restoration of dignity, flourishing, well-being, autonomy, and happiness, for instance, might be seen as some of the goals of psychiatry. What those concepts mean and why they are valuable is not decided by psychiatry. In the "life world" these concepts often have considerable bearing on how well we think we are doing. We may use them as mirrors for self-assessment: (dignity) I see that I helplessly demean myself in my various relationships; (flourishing) my life appears to be going nowhere; (autonomy) I have too little control over myself; (happiness) I am utterly miserable. Psychiatry is

constantly infiltrated by those concepts though practitioners' own senses of what counts as a healthy life. These senses vary. To cite a clinical perspective:

> For some clinicians, delivery of therapy merges with their response to the problems of daily living. For this kind of therapist, mental health disorders are indistinguishable from ordinary human challenges and so they regard more narrowly defined medical approaches as lacking an appreciation of holistic human reality. Other therapists attempt to transcend the day-to-day issues and instead see their role as helping people to face the universal existential reality, which is the inevitability of our death. This view of therapy celebrates the ultimate achievement of personal autonomy, the freedom to make choices, to turn away from some options, and to select sustainable alternatives. When the resulting psychological outcome is an autonomous one, the therapist regards this as progress on a journey towards ultimate self-actualisation. The best approach to mental health care is to place human rights at the heart of any recovery plan… (Lucey 2014, 20-21)

Certainly, it is not the case that every psychiatrist operates with this range or even any of these particular values in mind. What is significant in this statement, though, is that it foregrounds, without any apparent need for argument or defense, the place of values in the very business of clinical practice.

Alongside practitioners' ideas of what would make for an effective life are patients' socially sensitized understanding of their own impairments. Psychiatry modifies its own conception of treatment and cure in response to the new demands of those values. Glover reports the case of a woman who had overcome depression but who nevertheless was subsequently prescribed anti-depressants at her own request (Glover 2014, 235-6). The psychiatrist could find warrant from within the growing set of institutional beliefs around "distress" and "impairment" to support medicating in this situation. The protean nature of psychiatry – of its "kinds" – might partly be explained by its incorporation into its own thinking of those values. When it becomes evident that official psychiatry is at odds with the latest views on what a properly functioning person is then it is usually a matter of relatively little time before it puts itself into line with those views. This is just another way of saying that psychiatry is an historical

enterprise, dealing with people as they are broadly expected to be helped in the face of deficits, impairments and downright suffering which have come to seem helpless and unacceptable. The institution of psychiatry is presumed to have the authority to make those decisive determinations even as it itself is responsive to shifting values.

Elucidation 4: Heteronomous Influences

It is important to add to this contextualized analysis some account of the well-recognized influence of the pharmaceutical industry on the formation of some of the categories of mental disorder. The story is relatively familiar. Certain chemical compounds are identified (by their manufacturers) as effective in alleviating the suffering or impairment that goes with certain emotional and psychological states. If those states can be characterized as "illnesses" then drugs can be profitably licensed to treat them (Horwitz 2002, 78). These commercial opportunities are not left to chance. Organic illness status is precisely what the industry needs. (i) Where a drug is effective in eliminating or reducing the symptoms of an existing disorder not previously or reliably treated by drug therapy that disorder comes to be considered a disorder with an organic basis if the drug can be included among treatment options. (ii) In the case of a distressing psychological experience which is investigated as a possible disorder the fact that its affects can be eliminated or reduced by drugs suggests it has an organic basis and it might therefore be a true – paradigmatically causal – psychiatric disorder. (iii) When ordinary struggles can be made easier by drugs the same line of thinking is likely and the struggle moves into consideration as a disorder. In all three cases the curative potential of the drug gains growing influence in how the state is understood: "Once a method of remedying a particular condition is developed and placed in the hands of medical practitioners, that condition tends to become reconceptualised as a medical problem" (Elliott 2004, 429). There is much to trouble us in the fact that these determinations are commercially driven. That alone is not, however, a decisive argument against psychopharmacology. determinations of psychiatry. The clinical decision to introduce drug therapies is motivated by the desire to alleviate helpless suffering. In that respect it is consistent with the moral mission of psychiatry. Many patients are, we well know, adequately treated with drug therapies. That is acknowledged even when the precise interaction between drug and personality is unclear and the placebo effect is a matter of concern. There are ongoing conflicts about the appropriate treatments for given disorders: pharmacology, psychotherapy,

both or something outside the clinic? Which one gets at the reality of the disorder, tackling it at its vital point? From the point of view of the clinic the right question is one about which treatment alleviates the suffering or impairment in a way which satisfies the patient's and clinician's shared sense of improvement. This too, though, is a contextual matter for many of the major disorders, depending as it does on prevailing views about the self and its power to improve, the value of will driven recovery, the moral acceptability of the passive option. The answers to questions like these may vary from situation to situation and individual to individual. There is, though, an aspect of this issue which bears on the natural versus practical kinds issue. Pervasive drug therapy can arguably underpin the perception that mental disorder is essentially an organic problem, the root of which is more or less targeted by the drug. At the more philosophical level, this tendency may also promote the view that mental disorders, amenable as they are to chemical reversal, are natural kinds.

Elucidation 5: Psychiatric Science as Descriptive not Legislative

In this paper mental disorders have been elucidated as practical psychiatric kinds, rather than natural kinds. It is evident, though, that psychiatry has a scientific character. This is apparent in the ways in which disorders are formulated and used to frame discussions of treatment. But science actually plays a formal rather than substantial role in this context. It provides a kind of way of speaking – a professionally useful and economical discourse – about disparate representations: the ways in which phenomena are described bear the features of the form of working hypotheses. They may allow, in some cases, a more convenient route to an assessment than an open-ended psychoanalytic style engagement where nothing is presupposed about the patient. In reality, those hypotheses are precarious, resting as they do on the interaction between psychiatrist and patient. Nevertheless, this way of speaking about the phenomena of helpless suffering is intrinsic to the institution of psychiatry as it currently stands. It fulfils that institution's scientific identity. But that identity, I have claimed, is subservient to psychiatry's particular moral mission. What is at stake in these disorders from the practical point of view is independent of kinds-in-nature concepts. In this respect the scientific language of psychiatry does the work of, what Carl Hempel describes of science in general, permitting "an adequate description of things and events that are the objects scientific investigation" (quoted in Thornton 2007, 170). The criterion of adequacy, we might add, can be internal to the specific

practice. In psychiatry, this will mean descriptions that "adequately" facilitate exchanges among mental health professionals of information about a patient's general condition which are, nevertheless, intelligible to the practitioners involved as no more than a rough approximation: "a shorthand means of communication between members of the professional group" (Tasman and Mohr 2011, 32). Hempel adds that a second element – what we might refer to as the substantial element – of scientific vocabulary is "to permit the establishment of general laws or theories by means of which particular events may be explained and predicted and thus scientifically understood" (quoted in Thornton 2007, 170). A number of mental disorders may indeed be amenable to this lawlike formulation (the neurocognitive disorders noted above). But there are too many exceptions to think of something like Hempel's second element as genuinely characteristic of what is found in general in the diagnostic manuals. Psychiatry's scientific character lies in the first element: adequate description.

Critique?

The account I have offered of mental disorders might seem to be quietist. It takes no view on whether psychiatry *ought* to develop its own kinds. (That is not to say that a revised view of psychiatric kinds might not have implications, for those who wished to pursue them, for the perception of psychiatry among the sciences.) And nor does it raise questions about the quality of the supposed general good that is served by this discipline. There is also the question of whether the notion of a practical psychiatric kind lies ultimately on the side of anti-psychiatry. If it is seen as an account of the cultural mechanisms of medicalization then it might well be recruited to that cause. I for one am not always moved by the notion that psychiatry is taking away our humanity. Timeworn lines from mid-twentieth century philosophies of existence are too often cited as edicts against it. I certainly am worried by the crude application of the categories of mental disorder that characterizes the work of certain kinds of psychiatrists. The effects of that work are often damaging, misleading the patients affected into a diffident or anxious future. To draw any over-arching conclusions, though, that are pro- or anti- psychiatry on the basis of this feature of psychiatric culture – significant though it may be – is an exercise in grandiosity.

One similarly ambitious way of entering into a critical assessment of psychiatric kinds is by means of critical social theory. That tradition urges us to situate social practices

within a larger totality whose interests may not ultimately meet our ideals of freedom or self-realization. More specifically, the worry must be that mental disorder as a social product is an expression of societal power. This product's role is to designate as "illness" or "disorder" behavior which does not conform to the "normal" and "natural" requirements of organized society. By this means society is legitimated and those who cannot participate correctly can look forward to a cure and subsequent re-entry into the right life, or else permanent exclusion. In this regard mental disorders can be considered to be purely – what can be labeled – "ideological kinds." The mistaken perception of these "ideological kinds" as natural kinds, the theory goes, has the effect of deflecting attention away from the restricting and "pathologizing" demands of society. The focus instead is turned toward the illness that supposedly lies *within* the individual (see Gert and Culver above). Disorders require a resolution, otherwise the sufferer is objectively incapable of leading the same kind of "natural" "normal" life that integrated members of society enjoy. Surely, then, psychiatry is an institution which needs to be assessed with great wariness, rather than softly handled with a sort of pragmatist elucidation.

I am in sympathy with the general sentiment at work in this claim. It is difficult to disconnect much of what we consider clinically abnormal from what is thought of as unsuccessful in a society like ours. However, we should be cautious about pursuing social criticism by way of general overview. An obvious difficulty is that it implicitly sets itself the task of demonstrating that all or most disorders have some functional relationship with social power. No scope is left for an assessment of psychiatry which might see it as geared towards the alleviation of helpless suffering that is not genuinely explicable through social arrangements. In this respect it threatens to become as reductive an approach in its own way as the biological elimination thesis. But a critical relationship to psychiatry of a different type is made possible by the practical psychiatric kinds approach. The elucidation of psychiatric kinds is not, in fact, as quietist as it seems. It does not leave psychiatry untouched. Rather, it brings to light the profoundly normative character of psychiatry and its independence from the constraints that kinds-in-nature notions impose on other branches of medicine. This is not an effort to expose what some might see as the "merely" conventional status of mental disorder. Where psychiatric practice is effective it is because its participants are responsive to the norms which mark out this particular institution. Until this

normative character is brought to the surface psychiatry will continue to be misunderstood as operating within the protected regions of the mechanical sciences. By appreciating that psychiatry is an enterprise guided by prevailing notions of human fulfillment we gain entry to the questions of which conception of a good life it wants to promote, what idea of a human being is it likely to encourage. Each disorder, indeed every diagnosis of disorder, may give a different answer to these questions. Many – and conflicting – models of a good and normal life are implicit across the colossal range of psychiatric practice. As we have seen, some commitment to these models may have its origin in the broader life world, or in the self-interests of industry. It might just be that all of these forces give rise to a satisfactory medical discipline. Or the opposite may be true. But the notion of a practical psychiatric kind – a kind that is represented wrongly as a kind-in-science in principle – motivates normative scrutiny of the clinical conclusions offered by psychiatric practice.

References

APA / American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders* V. Washington DC: American Psychiatric Publishing.

Beebee, H. and N. Sabbarton-Leary. 2010. Are Psychiatric Kinds 'Real'? *European Journal of Analytic Philosophy* 6.1, 11-27.

Charland, L. C. 2013. Why Psychiatry Should Fear Medicalisation. In Fulford et al. (2013).

Charland, L. C. 2004. Moral Treatment and the Personality Disorders. In Radden (2004).

Cooper, R. 2013. Natural Kinds. In Fulford et al. (2013).

Elliott, C. 2004. Mental Health and Its Limits. In Radden (2004).

Fulford, K. W. M. et al., eds. 2013. *The Oxford Handbook of Philosophy and Psychiatry*. Oxford: Oxford University Press.

Gert, B. and C. M. Culver. 2004. Defining Mental Disorder. In Radden (2004).

Glover, J. 2014. *Alien Landscapes? Interpreting Disordered Minds*. Cambridge, MA: The Belknap Press of Harvard University Press.

Graham, G. 2010. *The Disordered Mind: An Introduction to Philosophy of Mind and Mental Illness*. Abingdon: Routledge.

Hacking, I. 1999. *The Social Construction of What?* Cambridge, MA: Harvard University Press.

Haslam, N. 2002. Kinds of Kinds: A Conceptual Taxonomy of Psychiatric Categories. *Philosophy, Psychiatry, & Psychology* 9:3, 203-217.

Horwitz, A. V. 2002. *Creating Mental Illness*. Chicago, IL: University of Chicago Press.

Kingma, E. 2013. Naturalistic Accounts of Mental Disorder. In Fulford et al. (2013).

Lucey, J. 2014. *In My Room: The Recovery Journey as Encountered by a Psychiatrist*. Dublin: Gill and Macmillan.

Phillips, J. et al, 2012a. The Six Most Essential Questions in Psychiatric Diagnosis: a Pluralogue. *Philosophy, Ethics, and Humanities in Medicine* 7:3, 1-29.

Phillips, J. et al, 2012b. The Six Most Essential Questions in Psychiatric Diagnosis: a Pluralogue. *Philosophy, Ethics, and Humanities in Medicine* 7:8, 1-16.

Phillips, J. et al, 2012c. The Six Most Essential Questions in Psychiatric Diagnosis: a Pluralogue. *Philosophy, Ethics, and Humanities in Medicine* 7:9, 1-15.

Radden, J. ed. 2004. *The Philosophy of Psychiatry: A Companion*. Oxford: Oxford University Press.

Sabbarton-Leary, N., L. Bortolotti, and M. R. Broome. 2015. Natural and Para-Natural kinds in Psychiatry. In *Alternative Perspectives on Psychiatric Validation: DSM, IDC, RDoC, and Beyond*. ed. P. Zachar et al. Oxford: Oxford University Press.

Szasz, T. S. 1960. The Myth of Mental Illness. *American Psychologist* 15, 113-118.

Tasman, A. and W. K. Mohr. 2011. *Fundamentals of Psychiatry*. Oxford: Wiley Blackwell.

Thornton, T. 2007. *Essential Philosophy of Psychiatry*. Oxford: Oxford University Press.

Zachar, P. 2002. The Practical Kinds Model as a Pragmatist Theory of Classification. *Philosophy, Psychiatry, & Psychology* 9:3, 219-227.

Zachar, P. 2000a. Psychiatric Disorders are not Natural Kinds. *Philosophy, Psychiatry, & Psychology* 7:3, 167-182.

Zachar, P. 2000b. Folk Taxonomies Should not Have Essences Either: A Response to the Commentary. *Philosophy, Psychiatry, & Psychology* 7:3, 191-194.

Notes

I am grateful to colleagues in University College Dublin for their comments on earlier versions of this paper, especially to Alena Dvorakova for her many detailed criticisms of the text's arguments.

[1] DSM II (1968), c. 130 pages, DSM III (1980), c. 500 pages, DSM IV (1994), c. 900 pages, DSM V (2013), c. 980 pages.

[2] See Kingma 2013 for criticisms of the implicit bias of both Wakefield's notion of harmful dysfunction and Boorse's biostatistical theory. Both of these conceptions, Kingma plausibly suggests, are directed by established normative ideas rather than neutral conceptions of disorder.

[3] This view is also expressed by Whooley: "Clinicians, on the other, understand relevant psychiatric knowledge differently, adopting a more practical posture toward knowing… It operates in the realm of the concrete, the temporal and the presumptive. The goal is not universal knowledge for its own sake, but practical intervention through case-based reasoning… clinicians are not interested in identifying a universal truth but a particular one – what will work for a specific patient" (Whooley, in Phillips et al 2012c, 3).

[4] Frances expresses a view somewhere in the middle, in which the practical ends of psychiatry are looped back into the development formal categories: "Much has been written about the 'validators' of psychiatric diagnosis and how they should influence DSM. The problem is that available information on the validators for most diagnoses is usually equivocal and inconsistent – validators never reach out, grab you by the throat and say 'Do it this one way or the science gods will be displeased.' To my mind, by far the most important validator is how will any decision help or harm patient care, given the foreseeable circumstances under which it will be used" (Frances, in Phillips et al 2012b, 11).

[5] And it is sympathetic to how psychiatrists in training are advised, by one textbook, to approach the DSM. The approach is pragmatic: "Clinicians must guard against the tendency to think that something has been explained when, in fact, it has only been named. In other words, giving a condition a label does not explain or confer any reality to it other than the name itself and the cluster of behaviors subsumed under it" (Tasman and Mohr 2011, 31).

[6] Graham offers one of the most encompassing *theoretical* accounts of mental disorder. He captures it with four theses. (i) The "rationality-disability thesis," which is impairment of rationality or "more fundamental mental faculties or basic psychological capacities of a person." (ii) There is "harm" thesis

captures effects stemming from "a special sort of source." (iii) The "mixed-source" thesis refers to the nexus of intentional activities and brute reality mechanisms which combine to produce the disorder. And (iv) a "some preservation of rationality" thesis in which some capacity for rationality is retained in impaired condition (Graham 2010, 156). Theses (i) and (iv), it seems to me, are quite enough to capture mental disorders in an inclusive way. The addition of theses (ii) and (iii) tilt the concept in favor of those disorders where there is a likelihood of some physical disposition towards impaired mental and emotional function.

[7] An interesting and challenging new proposal which tries to accommodate the psychiatric range while resisting the social kinds explanation should be noted: "According to the proposal, only natural kinds are appropriately labeled 'disorders,' whilst para-natural kinds are not. However, the scope of behavior that can be treated by psychiatrists is broader than the category of mental disorders, and can extend to para-natural kinds provided treatment decisions are subject to robust scrutiny" (Sabbarton-Leary, Bortolotti and Broom 2015, 88).