Chapter 8: Mental Disorder in practice

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8.1 Introduction: mental disorder concepts
A major theme of this study is the question of legitimacy. Previously, we examined the grounds for legitimacy of psychiatric classification and psychiatric science. This demonstrated tensions perhaps not unique to psychiatry, but presenting specific challenges not present elsewhere in medicine, e.g. how to accommodate explanatory pluralism without conceding to relativism, how to legitimately apply nomothetic knowledge to the individual, and how to reconcile societal and institutional demands and interests with those of patients. The concept of mental disorder itself is perhaps the nexus of such debates. If this concept falls, so does psychiatry, or so was the worry at the time Szasz (1961) accused psychiatry of promoting a myth to further social ends of order and conformity. Taken this way, the concept serves multiple qualifying and constitutive functions, e.g. demarcating the domain in which mental health
professionals are active, people suffering from the (alleged) disorder are legitimately allowed to use mental health services and are (partially) reimbursed for this, serving as a legitimate excuse in a moral sense, legitimizing involuntary admission and coercive treatment, or legitimizing investment of government expenditure in areas such as public health. The DSM has attracted controversy due to its central role in defining this domain. Two perspectives on its demarcation function are generally noted: firstly, defining the general category of mental disorder itself, i.e. demarcating the general domain, and secondly, sorting those phenomena within the general category. These two functions cannot be separated in a neat manner, since how one chooses to define the criteria for separate disorders needs to fulfill, or at least not go beyond, the general category concept and conversely, scientific, clinical, and social developments relating to specific categories may influence the general concept. For example, the inclusion of hoarding disorder as a new diagnosis risks extending the concept of dysfunction to include behavior which might better be understood as ‘unwise’ (Cooper 2014). Successive editions of the DSM have included a general definition of mental disorder, creating a touchstone for debate, one which has also featured in the literature in philosophy and psychiatry (e.g. Bolton 2008, 2013, Fulford 1999, Meynen and Ralston 2011).

Cooper (2004) criticizes the seeming lack of attention in subsequent DSMs to developing a legitimate account of the concept of disorder. There seems to be a skepticism, or at least agnosticism, about the prospects of defining disease, as evidenced by the comments in the DSM-IV and the DSM-IV-TR that ‘no definition adequately specifies precise boundaries for the concept “mental disorder”’ and that ‘the definition of mental disorder that was included in DSM-III and DSM-III-R is presented here because it is as useful as any other available definition’ (APA 1994: xxi). Since Cooper’s criticism, however, efforts have been made from the domain of philosophy and psychiatry to influence the debate within the DSM process, including the suggestion of the establishment of a Conceptual Issues Working Group (which was refused, Kendler et al. 2008). Later in this chapter, we will examine some of the arguments made in this debate. By way of illustration, the definitions offered in the DSM-III and (unchanged) in the DSM-IV TR are contrasted with the most recent DSM-5 version. Italics (by this author) indicate definitionally important concepts.
DSM-IV TR:

“...each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with significantly increased risk of suffering death, pain, disability, or an important loss of freedom... Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.” (APA 2000, p. xxxi)

DSM 5:

"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 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, p 20)

Changes and correspondences from DSM-IV to DSM 5 provide a first impression of current thinking on disorder. Stable assumptions are the following: mental disorder resides in the individual and manifests itself through cognition, emotion and behavior. There is distress involved, and a distinction is made between disorder and appropriate responses to stress and loss, and between disorder and social conflict and deviance. What has changed, is the slightly stronger connection to dysfunction, a hint of Cartesianism (‘underlying mental functioning’), less emphasis on individually experienced distress, and removal of the risk criterion.

In the accompanying remarks to the definition, the Task Force offers more clarity on its epistemic choices than in previous editions: it acknowledges the use of different kinds of validators in categorization, and specifies a priority: “Until incontrovertible etiological or pathophysiological mechanisms are identified to fully validate specific disorders or disorder spectra, the most important standard for the DSM-5 disorder criteria will be their clinical utility for the assessment of clinical course and treatment response of individuals grouped by a given set of
diagnostic criteria.” The manual also establishes the priority of clinical judgment in assessing need for treatment over fulfillment of listed mental disorder criteria. Attempting to separate normal from pathological symptom expressions is impossible in the face of a lack of clear biological markers or useful measurements of severity, according to the Task Force. It does appear that the Task Force has incorporated some of the remarks made from the philosophical debate (cf. Stein et al. 2010), though it perhaps more informative to notice which suggestions weren’t taken on board. For example, Stein et al. proposed a criterion of general pragmatic normative value on demarcation: “When considering whether to add a psychiatric condition to the nomenclature, or delete a psychiatric condition from the nomenclature, potential benefits (for example, provide better patient care, stimulate new research) should outweigh potential harms (for example, hurt particular individuals, be subject to misuse).” This suggestion was not incorporated, whilst we did see that just such deliberations have historically been part of the DSM Task Forces’ considerations. A deeper analysis of these developments is beyond the range of this project. What is more relevant is to note a number of concepts and distinctions involved: individual versus shared, causal relationships, the status of ‘dysfunction’, the role of ‘suffering’, ‘expectable’ reactions versus dysfunctional ones, and clinical judgment versus operationalization. For now, we will leave the DSM debate to turn to the wider debates on mental disorder and their relationship to actual practice.

This chapter is divided into three parts. A brief overview will be given of the philosophical literature on mental disorder, followed by the results of the final part of the qualitative study, examining the role conceptualizations of disorder play in actual practice, and finally the findings will be discussed. The overview of philosophical literature on the concept of mental disorder is based on recent reviews (Meynen & Ralston 2011, Bolton 2008, Glas 2008). This literature can be represented as a series of perspectives on mental disorder, some having developed in reaction to others. The models will be presented succinctly, together with main criticisms.

8.1.1. The disease model

Seen as the centerpiece of the traditional medical model, the disease model (sometimes referred to as the ‘lesion’ model or Virchowian model, after the founder of cellular pathology Rudolf Virchow) postulates a pathophysiological process as a cause of the disorder. The disease model is arguably the most influential and successful conceptualization of the experience of illness in medicine. The categorical approach to taxonomy is partially wedded to this model,
since it implies the presence of separate disease processes and its ultimate validation is projected to derive from the discovery thereof. Critics have pointed out of the DSM that, its professed ‘etiological neutrality’ notwithstanding, it implicitly supports the disease model. A problem for psychiatry has been to deliver on the promise of the disease model, which, many acknowledge, it has failed to do. One way of reacting to this failure is to replace pathophysiological causation with probabilistic correlation, in order to derive some kind of relationship between the body and the mind, without committing to pathophysiology. This takes the fairly ubiquitous form of referring to significant differences in neurotransmitter levels, brain sizes, regional blood flow etc. between groups identified within a mental disorder category and controls. Given that such correlations lack the sensitivity and specificity of *T. pallidum* in relation to syphilis, such correlation cannot serve to fully demarcate mental disorders (Bolton 2008). Often it is argued that such specificity, whether interpreted as correlation or causation, in principle cannot function as a boundary setter for general mental disorder, since all thought and behavior is related to brain function, and simply demonstrating such a relationship for a given set of phenomena does not prove that either the phenomena or the brain function themselves are disordered rather than simply different. Determining disorder involves a normative judgment which resists reduction, whereas the disease model is presented as a value-free conceptualization.

8.1.2. Statistical deviation

A definition less reliant on the identification of specific causes is Boorse’s concept of normal versus subnormal functioning in the statistical sense (Boorse 1975). This concept is also presented as value-free: normal functioning can be objectively ‘read off the biological facts of nature’. Deviance from a statistical norm of functioning, in this model, implies dysfunction. Presented in this manner, the problems with this model are readily apparent, and resemble those mentioned above: if, as is the case for mental functions, these generally follow normal distributions, where should the cut-off point be established to distinguish between normal and sub-normal functioning, without invoking behavioral functioning norms and hence begging the question? Another normative judgment must be made as to which reference group is chosen to determine ‘normal functioning’.

8.1.3. Harmful dysfunction

A relatively recent attempt to preserve a value free core at the center of a concept of disorder is Jerome Wakefield’s harmful dysfunction concept (Wakefield 1992). This concept has been widely discussed, and criticized, elsewhere (e.g. Fulford 1999, Thornton 2007, Bolton 2013). Wakefield does retain values within his concept, but captures them all within his concept of harm. His concept of
dysfunction, meanwhile, is intended to be value-free. To accomplish this, he wedds the concept of dysfunction to evolutionary function (a variation on Boorse’s biological function), and goes on to argue why such function is value-free. Subsequent criticism of the harmful dysfunction concept has focused on the latter argument. Many critics have argued that Wakefield invokes a teleological view of evolution which cannot be assumed to be true: we cannot determine whether the functions we currently possess are there because they have been selected for, or have yet to be filtered out of the evolutionary process. Also, Wakefield comes up against the same problem of normative selection of reference groups, only now in its evolutionary variant: how are we to determine the correct ecological niche for determining correct, or advantageous, evolutionary function? A related conceptualization of mental disorder of historical importance is Menninger’s (1963) failure of adaptation, which describes degrees of psychophysiological disorganization because of a failure to adapt to one’s environment in the present. This conceptualization was in place at the time the American government and American Insurers began to worry about rising costs of mental health care (see Chapter 4), and shows they were right to worry: the concept itself, being highly context-dependent, does not supply general criteria for demarcation.

8.1.4. Pragmatic and clinical concepts

Though perhaps this definition has a circular ring to it, defining disease as ‘that which health professionals treat’ does have an attraction to it, not in the least because in its agnosticism it avoids some of the criticisms above. It draws our attention to the historical and social contingency of professional arrangements and the fluidity of concepts, including those related to health and disease. Its main weakness is in its apparent lack of resources in affording a – definitional – legitimacy to the practice. If all that is binding the domain and its practitioners is historical tradition, then all it takes is a new social settlement to alter the state of affairs. This is not to say that the latter is easy, but that there are no inherent ontological resources for those opposed to resist this move. Defining disorder in this manner tends to reduce it to senses of harm and suffering, related to a measure of severity, and thereby seems to be too broad a definition (Bolton 2008). Nevertheless, Bolton stresses the advantages of this perspective, which are akin to a form of ordinary language philosophy: by tracking the descriptions and definitions given, for example, in the DSM, we get closer to a characterization of the general concept (a bottom-up conceptual approach rather than previously described top-down prioritizing of one epistemic perspective). Criticisms of the agnostic/pragmatic position can be derived from disagreements over the basic metaphysical position (e.g. Ghaemi 2012), and preferring a foundational philosophy such as realism or constructionism. Depending on how pragmatism is
conceived, the inherent instrumentalism may lead to objections on the basis of being insufficiently disciplined (a foundationalist argument) (e.g. Lemeire 2014), potentially inviting abuse.

8.1.5. Social construct
This position holds that mental disorder is a social, and mental category, constructed to meet certain ends. This is a nominalist position emphasizing the role of humans in defining and categorizing the phenomenal world. A commonly made mistake is to equate social constructionism with Szaszian critiques, since both seem to deny the reality of mental disorder. Szasz was, in fact, a supporter of the disease model of illness, and his main argument against the ‘reality’ of mental disorders was the lack of any clear pathophysiological findings to support the category (cf. Kendell 1975). In this sense, part of the antipsychiatry debate can be seen as an argument over how problematic the lack of clear pathophysiology is to psychiatry, between protagonists who share the same basic disease model of mental disorder (Fulford, Thornton & Graham 2006). Conversely, social constructionism argues for the reality and validity of socially agreed categorizations. From a social constructionist point of view, voting about the inclusion or exclusion of homosexuality in the DSM does not invalidate the DSM process scientifically: setting boundaries is a cognitive act. Hacking (2000) has described several versions of constructivism, reflecting the fact that there are intermediate positions between realism and nominalism.

8.1.6. Breakdown of meaningful connections
The central concept within this definition of mental disorder is rationality. Experiences and behavior that are difficult or impossible to understand, and which lead to significant harm or distress, are candidates for this category. This accords with folk conceptions of disorder in which failure to understand plays an important part (cf. Ahn, Novick, & Kim 2003) and meaning is perceived to run out. This definition prompts questions on the nature of the understanding in question, and the degree of variance we might expect this to entail: what to one social group might seem odd, e.g. a male running around in a skirt and carrying a tree trunk, is normal to another, in this case fellow participants in the Highland Games. To some this implies an unacceptable degree of arbitrariness. Viewed from another perspective, the definition evokes a distinction between ‘non-meaningful’ disorder versus ‘meaningful’ normality which has been challenged throughout history. The relativity of judgments of meaningfulness also applies to the bearer thereof, and much user literature attests to the meaning either embedded within, or attached to, experiences labeled as mental disorder. An infrequently mentioned added problem in this area is the fact that personal meaning is not a synchronic entity
that comes bundled up with individuals’ experiences, but is a result of diachronic reflection and self-relatedness with respect to such experiences. Ascriptions of meaning do not have a set temporal point, but are themselves reflections of personal development through time. Equally, this argument could be turned into a challenge to formulate a conception of breakdown of meaning which can accommodate these objections.

8.1.7. Action failure
Using the linguistic analysis of ordinary language philosophy, Fulford (1989) has offered a proposal for ‘action failure’ as an account of illness. The purposeful action of both artificial and bodily functions is central to his argument: action involves movement, and purpose is necessarily evaluative. Both bodily and mental illness, on his account, involve a failure of intended action in the absence of obstruction or opposition. Though this may seem not to apply to experiences of pain or evident psychopathology, Fulford construes these as experiences from which one cannot withdraw. An important implication of his work on disease and disorder is the idea that there is distinction between mental and bodily disorder on values. Fulford argues that the concept of illness necessarily involves values. There is a distinction, however, between mental and physical illness in the diversity of the values involved: for most bodily symptoms, e.g. pain, there is a broad consensus on their negative quality. Such consensus is more often lacking for mental symptoms, e.g. in the varied experiences of hallucinatory experiences (ibid.). Fulford’s account has been criticized for being both over-inclusive in its reliance on ordinary language, and for being unable to account for some conditions obviously included in the domain, e.g. coma (Nordenfelt 2001), disfigurement and unnatural sensations (Cooper 2007).

8.1.8. Failure to flourish
Megone (2000) refers to Aristotle’s ideas on the good life. Aristotle first explained what it meant for an organism to be a good specimen of its kind, and concluded that each organism has a characteristic life cycle. In order to follow this life cycle, it requires certain attributes, e.g. teeth for biting and chewing, wings, for flying, etc. Such attributes raise the opportunity for the organism to lead a good life, which to him comprises more than survival and reproduction, hence ‘flourishing’. In his view, human rationality is one such attribute. Cooper (2007) has criticized this concept for being over-inclusive: there are instances of phenomena that prevent flourishing life (e.g. laziness) which we nevertheless do not view as mental disorders, and the concept does not have resources for distinguishing immoral from disordered behavior.
8.1.9. *Family resemblance*

Lilienfeld and Marino (1995) refer to Wittgenstein’s concept of family resemblance. They conclude, as the reader might having read the above, that there are no necessary and sufficient features available to define mental disorder, and that the family resemblance approach may serve to defuse some of the problems: some disorders might be primarily characterized by suffering, others by breakdown of meaning, others by failure to flourish, and whilst there being a resemblance in place, there is no one common feature.

Many authors have pointed to the seeming intractability of the problem of defining mental disorder but equally, very few believe we should resign ourselves to a relativistic or skeptical view of the problem: the boundary issue is such a socially and individually important one in a moral sense, that we should not refrain from critically examining it. The positions marked out above are not a comprehensive overview, but do serve to illustrate a point: the search for a shared understanding of the concept of disorder can be viewed as through the lens of either different versions of foundationalism, or as forms of coherentism. Where the lesion model, Boorse, and Wakefield all seek to ground their definition in either the material or scientifically-derived functions, understandings such as failure of meaning, action failure, and family resemblance, depend on a form of agreement as to certain evaluations, implying a shared sense of meaning, and therefore, I would argue, coherentism. Pragmatic explanations veer towards social construction, though Zachar (2000b) would surely take a broader scientific pragmatic perspective encompassing both the material and the social. As Bolton (2013) notes, much of the discussion on disorder has been one of opposing foundational conceptions: biological versus social-constructionist. These conceptions were at loggerheads for a considerable time. As is evidenced by the comments in the DSM, there is now more evidence of a more pluralist, and contextually sensitive understanding of mental disorder. Could it be possible, that there is a broader agreement with respect to Fulford’s claim that “...if there is a lesson from twentieth-century philosophy for psychiatry today, it is that (post -Gödel, Wittgenstein, Quine, and others) foundations are not to be had” (Fulford 2013)? If so, what does this imply for the role the concept of disorder has as a defining, demarcating, and legitimizing concept? Should we conclude that this may be one of those examples of irrelevancy of philosophy to practice? Should practitioners be (made) aware of these arguments in order to achieve better practice? To get a better sense of these questions, the section of the qualitative study examining the role of concepts of mental disorder in practice should prove to be illuminating. It should be added that all the positions described above aim to define mental disorder from its medical perspective, i.e. in relation to the practice of medicine. Distress and
impairment are therefore emphasized. Understanding of ‘insanity’ (cf. Kusters 2014), however, is obviously not limited to these categories. The literature on experiences of persons diagnosed with mental illness contains untapped resources of meaning for our understanding of disorder, and in the view of many (e.g. Slade 2009, Davidson 2003) this conceptual gap is emblematic of the marginalization of meaning through medical discourse (Bolton 2013).

We now move to the results pertaining to the theme of mental disorder from the qualitative study.

8.2. Results from qualitative study
As described in the general methodology, the emerging themes were applied to modify the original theoretical framework. Three general categories were identified within which the themes could be organized:

*Concepts of disorder*
In Chapters 2 and 3 especially, conceptual interactions were described in the DEF. Either ostensibly or implicitly, one or more conceptualizations of mental disorder are expected to feature in the DEF, acting and being acted upon in the dynamic processes described. The concepts themselves are described here. This category contains all themes relating to the manner in which the general concept of mental disorder is defined by practitioners: material-biological, functioning and adaptation, loss of autonomy & freedom of the mental, suffering, family resemblance/ideal type, and social construction.

*Philosophy of mind*
This category denotes ideas on conceptualizations of the mind in relation to the body, encompasses materialism/reductionism, dualism, functionalism, emergentism, holism vs. atomism, and confusion.

*Interplay between ontology and practice*
This category describes features of the interactions between the conceptualization of mental disorder and other phenomena in the DEF. As concepts of disorder may be present before the start of the intake, and may be altered in the DEF, MD concepts are both constitutive and a result of this process. This category includes pragmatism, plurality, heterogeneity, relevance and context-dependence.

An important linguistic caveat should be mentioned before the results are presented, especially with respect to the translated excerpts. There are important differences between the Dutch and English language with respect to the terminology of illness and its meanings. In the English language, a meaningful
A distinction is made between illness and disease, whereby illness tends to relate more to an experiential state of feeling ill, and disease relates more to a causal process or entity. The two terms have different ontological connotations. In Dutch, however, no such distinction exists, and the term ‘ziekte’ is applied. The experience of feeling ill or sick is denoted by ‘ziek voelen’, and the causal process with ‘ziekte’ or ‘aandoening’ (affliction). Whether the term ‘ziekte’ is referring to a medical cause or the state of being sick, is often to be determined by the context in which the term is being used. In psychiatry, where the term disorder (‘stoornis’) is available as an alternative, speaking of ‘ziekte’ in relation to a mental disorder often does imply the connotation of ‘medical disease’ and the related ontological commitments. Sometimes, the adjective ‘real’ is added for further clarification (sometimes revealing materialism: disorders are really real if they are material). Therefore, in the excerpts, where ‘illness’ or ‘disease’ are being used, these may refer to the singular term ‘ziekte’, where the distinction has been made by the (bilingual) author based on the linguistic context.

1. **Concepts of disorder**
   - Material-biological
   - Failure of Understanding
   - Functioning and Adaptation
   - Loss of autonomy/freedom of the mental
   - Suffering
   - Family resemblance/ideal type
   - Social construction

2. **Philosophy of Mind**
   - Materialism and reductionism
   - Dualism
   - Functionalism
   - Emergentism
   - Holism vs. atomism
   - Confusion

3. **Interplay between ontology and practice**
   - Plurality of perspectives on MD
   - Heterogeneity
   - Pragmatism
   - Context-dependence
   - Practical Integration
   - Relevance

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Fig. 8.1. Mental Disorder framework
The three main themes may be characterized by their different positions with respect to practice. Concepts of disorder offer the content of various views on the nature of mental disorder and accord to a substantial degree to concepts found in the psychiatric-philosophical literature on this topic. Though these concepts were not often directly relevant to the psychiatrists’ task at hand, they were capable of accessing different MD concepts which they applied to practice and could motivate their significance. Philosophy of mind was a more abstract theme, mostly implicitly present, generally functioning as a relatively unexamined ontological backdrop for practice. The participants were less familiar with this theme and less capable of arguing for a specific (coherent) position. The third theme, Interplay, emphasizes the form or manner in which mental disorder concepts come into play in practice.

8.2.1. Concepts of disorder
This category contains the content of ideas on the conceptualization of disorder. Most of the conceptualizations described in the literature were found in the participants.

Material-biological
This is the ‘classic’, Virchowian model of mental disorder as residing ontologically in the material. The term ‘biological’, which in general use does not equal ‘material’, in this context is used by participants to denote materialism.

Example (institutional):
I: Can you tell me something about your own views on mental disorders, the nature thereof, how you see that generally.
Psy: Yes, yes. That has developed of course in the past twenty years that I’ve been in the profession, and I think that in recent years I tend to think and act more and more towards biological psychiatry.
I: And when you say biological psychiatry, can you explain to me what you mean by that?
Psy: Well, quite simply, trying to help people as adequately and carefully as possible with medication.
I: Just then you said that you...
Psy: (interrupts) Not that I’m not interested, I am actually, but I’m not clever enough to understand the brain; if you go to conferences and hear what’s known about it these days, I’m not someone who has steeped himself in that, you know? The biology and neurobiology, and the microchemical level, being occupied with that.
Failure of understanding
This criterion, which follows the traditional one of ‘rationality’ on the part of the patient, was previously (Chapter 3) seen to play an important role in the DEF, in characterizing phenomena as either psychologically determined, or materially (biologically) determined, with a corresponding ontology. As we saw there, failure of understanding renders a disorder at once more ‘biological’ but also more linguistically close to ‘disease’, and also, more severe. Interestingly, the ubiquity of the presence of the rationality criterion at the practice level was not matched with its presence as a criterion for mental disorder during the interview. This finding is examined further under the heading of ‘Interplay of ontology and practice’. For examples of this feature we refer to Chapter 3.

In this example, the discussion is on which concepts the participant (from an institutional setting) uses in judging whether a patient’s problems merit treatment within mental health care.

I: In involuntary admission assessments, there is a legal concept of disorder that is noted, and you could say, in principle, this should be the same concept, but equally, there might be some room depending on context. Is it the same?

Psy: I would call it the same, I think. Mental disorder should be defined, like that. Maybe the term ‘dysregulations’ fits better. I don’t think I really principally apply that disease or no disease… Recently we had an interesting case discussion about a man who is different from what he was and is full of religious and grandiose ideas but he can talk very convincingly about them. I’ve simply undergone a change… I’ve received a religious insight and I’m going to change the way I live my life, I feel chosen by God, etc. Everyone says… really sick! But I really wonder. A few colleagues in the circle said: really sick. But, I don’t know. Sick? Sick? Sick?

I: And what was the reasoning. You said he spoke convincingly…

Psy: He’s sitting there explaining clearly and coherently that it is a development in his life. It is different than before but the question is if you should interpret that in itself psychiatrically.

I: So for you the distinction of disease and disorder, thinking more of disorder, is related to a coherent, and at least partially plausible explanation. That you can follow how someone has arrived there. That is in this example. This person can explain very clearly how he came to this experience. You can understand him, the way he tells it.

Psy: It’s not decisive but if this man had been incoherent in his story, or had lowered consciousness and bad attention, then for me it would have been much more a case of disease.

In this example, the doubt in the psychiatrist’s mind was borne of the coherence in the reasons the patient had given for his experiences: his rationality. Note also that
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the psychiatrist also takes functional criteria (lowered consciousness, low attention span) into account, pointing to plural concepts being applied. Intact rationality was sometimes equated with speaking ‘realistically’ about oneself or one’s context, connected with the concept of ‘reality testing’ (participant from private practice):

**I:** Normally speaking you would see disease as something that is non-free?

**Psy:** Yes, in principle. If you look at drug addiction or alcohol you see that people who are under the influence are less capable of describing themselves and their circumstances than when they talk about it a day later. Then you see they are able to talk about what happened in a more sober and realistic way.

Another brief excerpt from an academic psychiatrist, on discussing the concept of mental disorder he applies in involuntary admission assessments:

**Psy:** I have a concept of that (mental disorder) of course, and fundamentally it’s a disorder of reality testing. That’s what I pay attention to. All else, if someone’s depressed then he can be depressed, even suicidal, but that doesn’t automatically mean that there is a requirement to intervene, in my opinion. As soon as there is a disorder of reality testing, then there is.

**I:** That’s what you find fundamental about mental disorder pertaining to involuntary admissions?

**Psy:** Yes. It’s a long discussion. Mental competency etc. My opinion is that we psychiatrists are not experts on competency of will. But we are with respect to disorders of reality testing. That is a concept we can work with, and competency, that is not our expertise. No-one really knows what the will is and therefore, no-one knows what lack of competency is. So in my view that is a legal concept. Judges can see that as they will, but we should limit ourselves to disorders of reality testing.

Understanding is not only a rational, cognitive process, but has an emotional component, see this example from private practice:

**I:** I’ve spoken to a lot of psychiatrists who do this kind of assessment (for involuntary admission). What kinds of ideas and practices help you with this?

**Psy:** Firstly, the stories people tell, whether you can empathize with them. If someone says he’s going to end his life, too bad for my kids, my wife, my employer, well, then I think, that’s hard to empathize with. How are your wife and children going to continue, your work? You have everything and you want to end everything. Someone else who had little social skills and no work, you can empathize with that more easily. Then you can say: you should seek help but these are not grounds for an involuntary admission.
Functioning and Adaptation

In the initial framework, ‘harmful dysfunction’ was one of the sensitizing concepts in relation to mental disorder. Indeed, ‘functioning’ and ‘dysfunction’ frequently featured in participants’ responses to the conceptualization of mental disorder. However, participants were almost entirely unaware of Wakefield’s ‘harmful dysfunction’ proposal, did not ubiquitously connect ‘harm’ to dysfunction, and no mention was made of an evolutionary explanation towards adaptation. Rather, adaptation was taken in its general biological-ecological meaning of adaptiveness to one’s actual current environment. The concept of function was applied at multiple (ontological) levels: socially, psychologically, relationally, cognitively, biologically.

Example (private practice):
I: We were talking about domains. At what level the client presents the problem... adaptation... you said that currently, complaints-oriented thinking is dominant.
Psy: Yes. Someone has a complaint, DSM type thinking... the classification. And those complaints can be remedied, you have to work in a complaints-oriented manner. While, naturally, someone’s functioning is also tied up in the classification. That’s important. I find complaints much less interesting than someone’s functioning. The adaptation concept, how’s your grip on the world around you, on yourself. That’s where it begins. And from that situation, getting a grip on the world. I think that’s much more meaningful, when thinking of individuals, than the complaints and symptoms themselves. Degree of suffering is sometimes involved, sometimes. But adaptation... How can someone create what he wants in concert with the environment. That’s what you want to improve with someone.

Example (institutional):
I: The question was: what is, from your own perspective, your own idea or concept of mental disorder?
Psy: Oh yes. Mental disorder is present if the mental apparatus is dysfunctioning in one way or another. Or is underdeveloped, has too few mental representations or is overwhelmed, for example by trauma. Then it doesn’t function, either. So then it isn’t fit for purpose or it doesn’t function as a processing system for coping with daily experiences. I realize this is very broad but...

Failure of function does not imply a singular level of dysfunction or reductionism. Most frequently, dysfunction was defined at multiple levels:

Example (academic):
I: Could you tell me what a mental disorder is?
Psy: Generally speaking? Then I would follow what we were just talking about: a
disorder that limits people’s functioning. That causes people to be different from how they were before.

I: So, a discontinuity, dysfunction is important and you mention disorder. Functioning is a kind of general term, and you were specifying it earlier in their state of being. So what do you mean by functioning, is it a social norm?

P: Essentially. Does someone have work? Is he or she still running the household well? How’s the family doing? Is someone maintaining the role as father or mother well? The role of partner, social integration in the environment. If we go back to this intake, this person has a very restricted life. She is functioning, but here role as a partner is limited, her role in the community is limited.

... [a discussion follows on Wakefield’s harmful dysfunction proposal]

I: At what level do you define the disorder? To put it simply, if you compare theories, and say define behavioral theory at the behavior level. Pathophysiological theories at the material level. So for different theories there then is a different ontology, the thing-like character is at deeper levels. Related to Wakefield, making disorder value-free, what if we could define disorder at an exclusively material level: there it is, that there. Then we free ourselves from a lot of arguing. Should this or shouldn’t it be a disorder. It could be an ambition, to do that. What would you think of that, is that desirable?

Psy: I don’t think that’s feasible. The examples you give are opportunities to influence a process that is going on there. There are different ways to influence that process. You can attend to a person’s conflicts with a psychodynamic perspective, and then you influence the whole too. You will see changes in the dorsal prefrontal cortex. Give someone medicine or ECT, then you see changes at a different level in the brain. Keep going and at a certain point an integration occurs which via prefrontal influences the executive functions. So, you have a process, and you can intervene in this process at different levels. In my area, the treatment of mood problems, CBT is highly effective.

I: But this is on how you intervene.

Psy: That’s what the theories are based on.

I: Still, you can still say you’re conceptualizing this process at a singular level, in this case, material. So the question is whether it is worth doing, localizing it at one level. Scientifically it is also important since I want to elucidate the cause and be able to demarcate it. You could also say, it’s not that important, or it’s not feasible.

Psy: It is very important, but I don’t think you’ll get a final answer. You can never get out of the argument. There will always be cultural norms involved whatever substrate or deviation you find. I see it simply as a manifestation of dysfunction at multiple levels.

I: So there will always be multi-level dysfunctioning. Going back to the discussion on the biopsychosocial model, then you cannot separate these levels. And since adaptation to the environment is involved, then you get to cultural and social norms,
and those norms become unavoidable. So that’s a philosophical position, that you can’t get the cultural norms out or reduce it to a value-free process.

Psy: Yes.

Loss of autonomy/freedom of the mental
Mental disorder is associated with a loss of autonomy. At one level, this is an obvious association with competence, grounding laws on involuntary admission and treatment, etc. Notable is the inherent mind/body dualism often apparent in the thinking on autonomy: with such dualism in place, autonomy is taken to reside in the mental, and can be encroached upon by material processes. In other words, the more a disorder or phenomenon is taken to be ‘psychological’, the more the person is taken to be responsible for it. Freedom and responsibility therefore align with the mental, and the converse aligns with the physical.

Examples:
Psy 1 (institutional setting):
I: What does mental illness actually mean? What’s the foundation, can that be put into words, and if so, how would you do that?
Psy1: Illness to me is associated with the aspect of responsibility. Illness belongs to a very medical causal disease model, something that happens to you and that you have little influence on. I’d rather speak of disorders. It’s called a personality disorder and I don’t view personality disorder as a disease or an illness. And then, to what degree can people stake a claim to collective resources to do something about it? That’s a quandary.

Psy2 (academic practice):
I: Okay, an easy one next. What are your thoughts on the nature of mental disorders?
Psy2: You’ve got to be kidding. What is a mental disorder? What an incredibly difficult question! Complaints that are so disruptive, being depressed, psychotic... that disrupt the cognitive or the emotional state... that it disrupts the own will, the own motivation, the own person. Am I boss over my own life or am I led, my control, autonomy, freedom, or am I led by something called a disorder?

Though loss of freedom is involved in mental disorder, not all disorders imply equal degrees of loss of freedom:

Psy3 (institutional setting):
I: There are people, to but it colloquially, who protest against the medicalization of life problems. Someone may need help, fine, but they need not get it from mental health care. A kind of antipsychiatric criticism. You would need, then, a motivation and especially in this domain, in which we speak of disorder. So the question behind this is: what exactly is mental disorder, what is the foundation, can it be put into
words and how would you put it into words?

**Psy3:** Being ill for me is associated with the aspect of responsibility. Disease is part of a very medical causal disease model, something that happens to you that you can’t influence very much. I prefer the term disorder. Something like a personality disorder I don’t really see as a disease.

Suffering

The term most frequently used by participants in relation to the burden of mental disorder, was suffering. It was noteworthy that the term ‘suffering’ was used very frequently, whilst the direct Dutch translation of ‘harm’ (*schade*), which one might expect from the perspective of the ‘harmful dysfunction’ model, was hardly mentioned. Degree of suffering was an important and ubiquitous feature of the concept of mental disorder.

Examples:

**Psy1** (academic setting):

**I:** Well, you might say this person is an outlier. This happens in biology. You don’t have to be sick for that.

**Psy1:** True. That is the case. You can still ask the question: is this person disordered in the psychiatric sense? But well, you look at the surroundings she’s from. That small village, in that community, raised restrictively, restricted by her parents. But the problem is that there is suffering and a help request. If the woman wasn’t suffering or didn’t have a help request, then fine. But there is a problem and the man also had a problem with his wife, so how can we help this person function better in one way or another.

**Psy2** (institutional setting):

**I:** A problem is something else. You have an etiology that hasn’t been elucidated, so neither physical nor mental, but there is suffering. What makes that valid as a disorder?

**Psy2:** Then you’re talking about an affliction. You want to see something. An affliction if someone has a pain problem. The complaint like pain.

**I:** You said, people have...

**Psy2:** Subjectively they feel bad. They are suffering from something. In that case, you could say: there is an affliction.

**Psy3** (academic setting):

**I:** Back to a different subject. What is a mental disorder then?

**Psy3:** It’s a brain disease. A brain disease is an affliction which (maybe a bit DSM-like but oh well) that is accompanied by suffering and by dysfunction, just like a lot of
other diseases. It’s characterized by a lot of interrelated symptoms that trouble people and which can trouble others as well. Also by a certain course, that does go a bit far but I think it is often accurate. Yes, I’d call that mental disorder.

Psy4 (academic setting):

**Psy4:** I object to the concept of disease, as a unit of disease. In psychiatry we don’t have, I think, diseases. We have syndromes. Symptoms, complexes that we have raked together which can serve as pragmatic units. But a disease like TBC or hypothyroidism? We don’t have it.

I: I’ve talked to people who conceptualize some disorders, for themselves, and use the word ‘sick’.

**Psy4:** That’s something else. In English, you have these distinctions: illness, disease, disorder. I sometimes judge people to be sick. But that doesn’t mean they have a disease. Certainly not a psychiatric disease. In practice, sometimes you talk like that. I try to teach students and residents that we don’t know disease entities like the rest of medicine, as pathophysiological units. We only have the concept of syndrome.

I: If you find someone is very sick, you said, ‘it does prompt me to think like that’, how would you describe your thinking then? What does that mean to you?

**Psy4:** If someone is very sick then he is suffering badly and is highly impeded in functioning.


**Psy4:** Yes, what someone is suffering from and is not under his control. It is not voluntary. He can’t say: now I’m depressed and now I’m not. It happens to people.

In the above excerpt, we also note multiple concepts of disorder being used simultaneously. This will be addressed below.

Suffering in itself was insufficient for diagnosing mental disorder:

Psy5 (academic setting):

I: You might say: the mental disorder concept isn’t that important. I just look at the degree of suffering and how someone’s functioning. If someone isn’t functioning well there is much suffering so...

**Psy5:** No, that’s not enough. I don’t think so.

I: How then would you put it?

**Psy5:** In the end, I can discover a psychiatric disorder in this. So it isn’t just suffering. There is much suffering that is neither psychiatric nor somatic disease. And for me there must be a psychiatric disorder and what that is, can be found in our textbooks. Beyond that, I have no answer.
Family resemblance/ideal type
In this way of thinking, there is a taxonomy of mental disorders (generally the DSM), and individual phenomena more or less resemble these criteria. When speaking in this manner, participants refer to the number and severity of symptoms corresponding to the DSM-classification. They also add, that this is disorder ‘because this is what we have agreed upon’, being neutral to its either natural or socially constructed status. This in itself, as the DSM states, is insufficient to determine the presence or absence of disorder, and therefore, some additional criterion of degree of ‘dysfunction’, harm, and/or suffering is added. In this category, the codes were included where participants refer to the presence of features such as hearing voices, depressed mood, suicidal thoughts and behavior, disordered thinking and/or behavior, severe panic attacks, and the connection between these local instances and the abstract (taxonomic) concept is a factor in the decision of whether there is mental disorder. Within these features (see also Chapters 3 and 4) there are some which are more associated with ‘disease’ or ‘real sickness’, prompting the resulting identified MD concept more towards a material/biological ontology. This category mostly consists of products from the descriptive mode of questioning from Chapters 3 and 4, but this need not be the case: pattern recognition may also be related to narrative and meaningful structures that have been stored, e.g. as illness scripts, in the memory of the clinician. This manner of determining ‘mental disorder’ based on likeness implies an agnosticism, in practice, to the question of what a mental disorder is or should be: the concept of mental disorder that is implied or embedded within the ideal-type mental disorder of which the constellation of features in practice is deemed to be an instance, is imported into the DEF along with the disorder (though this may not be as explicit as this suggests).

An example of recognition, from an institutional setting. In the previous discussion on demarcation of disorder in involuntary admission assessments, the participant expressed a number of social adaptation criteria on disorder, and the interviewer noted a possible discrepancy with the MAQ questionnaire:

**Psy:** If someone in Suriname believes in Winti and behaves according to cultural norms, then that is no disorder. But if someone shows behavior that is unacceptable and more extreme within that culture, and is hindered by it, is more bizarre than fits the culture, well, not everyone is hindered themselves, like in mania, they don’t suffer themselves, but others do, socially someone is dysfunctioning rather strongly based on bizarre behavior, then I see that as a disorder.

**I:** If you explain it like that, it sounds like a very social criterion.

**Psy:** Amongst other things.
I: If we look at the questionnaire, then you disagree with sociocultural definitions of mental disorder. And you disagree strongly with antipsychiatric approaches, which emphasized the social elements. So if you emphasize the discrepancy between someone’s functioning and the local culture as a criterion, then you might take that as a sociocultural definition of disorder.

Psy: But that is too limited since a sect, in which everyone is incited towards suicide, again within a certain local culture, I don’t think that’s normal.

I: Okay, so what should be added in your view? Being socially extreme isn’t enough.

Psy: No. It’s a combination, a combination of the behavior someone displays, the psychiatric color it has, in the sense of, is someone depressed, suicidal, then it isn’t normal, and it fits a psychiatric disorder.

I: So an important criterion for the presence of disorder is pattern recognition and conforming to recognized psychiatric categories?

Psy: Yes.

Example, conforming to taxonomy ideal type, from the academic setting. In the following the ability to recognize the symptoms as conforming to the pattern of a recognized disorder syndrome is relevant. In the discussion leading up to this point, the focus was on the process of the actual intake itself.

I: Back to the general questions: If you look at this person, would you say it’s valid and good that this person is receiving treatment in a mental health care setting, that this belongs to psychiatry?

Psy: Yes. Because, as far as I remember, there was severe disorder here. The complaints were long periods of depersonalization, negative thoughts about others and strangers, that they wished him dead, thought he was worthless, and he couldn’t distance himself from these thoughts. Put briefly, I have the impression that he’s suffering, and that this can be traced back to a mental disorder. That certainly belongs in mental health care.

Social construction
In this context, this is the acknowledgement that social values and human judgments are involved in defining and demarcating mental disorder.

Example (academic setting):
I: How do you distinguish what should and shouldn’t fall within the domain of psychiatry and help here?

Psy: Especially if I have the feeling that a patient will benefit from it. If I have something to offer. I have a limited therapeutic arsenal. That is: medication, talk sessions (insight-oriented, cognitive-behavioral therapy, light therapy, clinical and
day-clinical treatment and of course progressive relaxation therapy).

I: PRT! I must remember that.

Psy: Spread the word. Anyway... If I have the feeling that I can do something about the problem and I have something to offer, then it's psychiatry. If I don't have that feeling and I think – this is a patient who has a lot of complaints but I won't be able to address them, it can be psychiatry but just not psychiatry I can do something about. Say it concerns a person with an intellectual disability and behavioral problems, slightly, ADHD-like, then I don't really know how to handle that.

I: What would you say about a kind of Szaszian criticism, saying, what is this nonsense, you're going to treat everyone you think you have something to offer. You're medicalizing social problems. People trying to dupe the system looking for a disability benefit, you'll treat because you think you can help them, while us taxpayers cough up the money. Or, more seriously: recent criticisms from Wakefield, and from Szasz, say psychiatry has overextended its domain. Szasz made an absolutist claim: Mental disorders don't exist. It's social normative things going wrong and that's the input. He pressured psychiatry into furnishing a demarcation. Psychiatry then proceeded to do that, to a degree, by way of biology. That could lead to a criticism of a kind of pragmatic beneficence principle like you stated just there.

Psy: Szasz' criticism is like the criticism you could have of the way we divide time into night and day. Everyone knows what it is, everyone knows there is a day and night period. If you ask: where is the distinction, where is the border? Then it is a border we devised.

I: Yes, but Szasz is saying night therefore does not exist.

Psy: I think he says: the distinction we make between night and day is hypothetical. So everything is the same.

I: Yes, everything is day.

Psy: That's where I think the nonsense lies. There is a day and night period. There is insanity and non-insanity and the border between the two is very hypothetical and it can change per culture and epoch. But, you have to work with it!

I: So actually you'd say: Listen, Szasz, social realism. We've agreed to these things, that's a fact! It's a fact you can't deny.

Psy: What I think is important: it's a set of agreements that were made. If you don't have those you get a mess. Then everyone who sees a profit, or a handy investment, can come into the market and say: "I have aromatherapy and I have foot-reflex therapy." There are of course many kinds of treatment that could be propagated. At least the money side is well-protected now. Some doctors too do wrong things, but at least the risk of patients being fleeced is low, and that does happen with some alternative therapies.
An example from an institutional setting:

**Psy:** I think we aren’t actually entirely certain of what psychiatry is, exactly. Psychiatry... does it actually exist in and of itself? Is it an entity or something? Should you call it a something, or is it more of a collection of various activities and shifting ideas about what we are doing. It isn’t something constant. From that perspective, input from all corners and laws in all kinds of domains are applicable, I think.  

**Psy:** Yes.  
**Su:** I can put it like that?  
**Psy:** Yes, human influence is indeed that big so we simply have to make do.

Another academic psychiatrist:  

**Su:** The idea of isolating part of the disorder concept and analyzing it in a value-free manner, to arrive at a certain norm of what a disorder is, do you see that as a viable perspective or not?  

**Psy:** I don’t know. See, this is how it manifests in the first instance in an intake or in contact with people. That will never, I think, be value-free. Because there is always culture, context, the zeitgeist. They’re always involved. But that’s a beginning, to seeing what’s beyond that. What disorder is present and what’s behind the disorder? Can you find a biological substrate for it?

This shows a feature found in a substantial number of participants: an acknowledgement of the presence of culture-bound norms in the manifestations of mental disorder, coupled with the hope and/or faith that science will deliver biological clarity to the causes thereof (thereby reducing the disorder concept to value-free criteria).

8.2.2. Philosophy of mind  

As a whole, participants’ familiarity with philosophy of mind was very limited. Specific training in this area is not offered throughout standard medical or residency training in psychiatry. Views of philosophy of mind therefore were often implicit and either derived from discussing interactions in the intake or answers to the questionnaire. Philosophical views of participants are presented in the following under several themes. The titles do not imply that all participants
 favored this position. Either support or rejection of the position is noted under the headings.

Materialism and reductionism

For most participants, the concepts of disease and dysfunction were connected to material ontology. For many, the general concept of disorder was equally linked to materialism. ‘Disease’ as a concept was more strongly linked to materialism, but a distinction was made between the ontologically more heterogeneous concept of disorder and that of disease. As discussed below under heterogeneity, not all disorders were seen as equally materially determined. A higher ‘material load’ ontologically was associated with viewing the diagnostic concept as more disease-like, and more medical. This underlined the conceptual associations and alignment found in previous chapters between materialism, concepts of disorder and disease, and the ‘medical’ category both as object and as professional role.

Example, academic setting:

I: What is a mental disorder?

Psy: I’d say it corresponds to psychiatric illness and then I do go to the medical model. A disease that expresses itself, not so much with physical complaints as with psychopathology. The mental functions are disrupted. The cognitive, the affective. These can go wrong at all levels. One form distinguishes itself more by cognitive dysfunction, the other more in affective dysfunction.

I: At what level do these dysfunctions exist?

Psy: You mean? At brain level, I think... biological level mostly... hmm.

I: You’re talking about functions, right? I’m not going to elaborate, you know.


I: Biological disruption lies in the brain?

Psy: Yes, primarily determined by the brain. I think.

I: So when there is a mental disorder, there is a disease. A disease that is associated with dysfunctions at different levels, in different categories of cognitive/affective and perhaps social functioning. But the core is located at the level of the brain? I could ask: do you see functions as something material or immaterial?

Psy: I’d sooner say material.

I: How do you find out whether a material function is dysfunctioning?

Psy: Well, at various levels. Perhaps in your clinical or psychiatric examination. You have some reference framework of what it should be. How the function should be, how it should manifest itself. That is your first diagnosis. After that you might have others... but that’s not what I’ll derive my first diagnosis from. You can examine it further of course but...
In the following example, Wakefield's harmful dysfunction model was being discussed (academic setting):

I: Wakefield connects it to evolutionary theory. Functioning and dysfunction can be embedded in an evolutionary perspective. Related to context, adaptation. If you look at it that way, you could find a foundation for mental disorder that is less controversial. In the Seventies it was controversial, a phenomenon that keeps returning. Now you have the ADHD discussion. Do you see his suggestion as promising?

Psy: I don’t know. See, this is how this presents itself in an intake and in contact with people. That will never be value-free, I think. Because culture and context, the Zeitgeist, these always are involved. But this is a beginning, a beginning of looking what’s behind this. What disorder is involved and what is beyond the disorder? To what degree can you find a biological substrate for it?

I: Biological substrate... you mean something material?

Psy: Yes, something that you can determine with neuroimaging or can image in a different way.

This view did not preclude attending to mental and social functioning, as these are seen as based on such brain functions, rather the views represent a metaphysical view of the mental disorder concept.

Another example, from the private setting. The discussion is on theoretical pluralism.

I: There is a kind of tension in the sense that it is important to find the right level, the level as given in nature. There is a reality out there and we should try to get as close to it as possible, to describe it. That’s what science is. And that will have to happen in psychiatry too. One argument to perform a certain kind of science. An idea on science and progress. On the other hand, you could say that psychiatry should stay very pluralist and expressly should not let itself be forced into singular causal specifications. But that leaves from the premise that it would be principally impossible to find one of those. For the palette of psychiatry, it would be difficult to do so. Some people say that reduction is possible in principle, others that it’s impossible. What’s your idea?

Psy: Impossible. The reduction to that one area you’re focusing on, where of course there’s something going on, and where you can find something material or deviant, to trace it back there. It is an expression, you could say. A manifestation. But it is not the essence of the disease. If you reduce it to that then I think you’re not only doing people a disservice but science too. That you’re using a limited perspective and losing sight of other things. Like an epidemiologist who only looks at infected cells, and not
how a virus is transmitted. From a pragmatic perspective, this would be very bad, as well.

Often, but not always, accompanying materialism was the notion that the brain generates mental and other functions, apparent in the following excerpt of an interview with an academic psychiatrist.

**I:** What is a mental disorder?

**Psy:** A brain disease. A brain disease is an affliction (a little DSM-like but oh well) which is accompanied by suffering and dysfunction, just like many other diseases. It is characterized by a number of interconnected symptoms that people, or their environment, suffer from. Characterized by a certain course (that goes a little far) but I do often think this is true. Yes, that’s what I’d call a psychiatric disease.

**I:** Okay, so the connection is between symptoms and course. And the central characteristics are suffering and dysfunction. Are you familiar with Wakefield’s concept of harmful dysfunction?

**Psy:** No.

**I:** In philosophy and psychiatry there has been discussion on the foundation of the concept of mental disorder. You say: brain disease. If you say: it’s suffering, dysfunction, connection, symptoms, characteristic, course, then I do not yet see the brain disease there.

**Psy:** Why not?

**I:** If you elaborate in thus way it still is descriptive. In the sense… everything you say… suffering, dysfunction (which becomes apparent in the environmental context), connected symptoms, are all descriptive. Characteristics and course are descriptive. They don’t necessarily make it a brain disease.

**Psy:** No, but what would it be otherwise?

**I:** Of the person, of the mind, for example.

**Psy:** Yes, but what is the mind? Hmm, okay. No, I think you can really say the disorder is generated. Take van Praag’s model. It’s not the dysfunction of the brain, the dysfunction of the brain runs parallel to it. It’s something else.

**I:** The brain is the carrier and the substrate is there?

**Psy:** Yes.

**I:** But why prioritize the brain in this way?

**Psy:** And not… something…else?

**I:** Like, say, your whole body.

**Psy:** Oh, that’s very clear. The brain is connected to the whole body via the autonomic nerve system and via hormones. Of course, people experience their mental complaints in their body, per definition. It isn’t them carrying on, it’s real! But they are generated centrally. At least interpreted in such a way that people get frightened or worried.
They don’t feel comfortable. I really think the brain fulfills a central function in this process. If there are certain influences, which we are unaware of that lead to dysfunction then symptoms can arise of varied nature and recognizable as psychiatric states.

A substantial number of participants employ what seems to be a form of nonreductive, interactionist dualism to combine a foundational role in mental disorders for the material, whilst preserving a substantial role for the mental. Here an excerpt from an interview with a psychiatrist working in an institutional setting.

Excerpt:

**Psy:** Experiences can be of such a nature that damage occurs and you come to speak of medication, so that biological side is there too.

**I:** You see that as a biological side.

**Psy:** Yes, but biological damage caused by interactional damage, like in a rat that you separate from its mother after birth, you see that happening and that’s the case in humans too, but what someone carries with him of his history, explicitly and implicitly, his history, plays a very important role in this, so it’s also relevant with medication. If only because, you can treat a depression with antidepressants, but there is always something that has happened, and you only find out if you establish a relationship with them. And then you see the whole interaction between the patient, his environment and the biological side, it’s both.

**Dualism**

This is the assumption, generally held implicitly, that the mental and physical are two different ontological realms. Even whilst ostensibly ascribing to some form of mind-body holism, a large majority of participants nevertheless divide both causes and disorders between more or less ‘biological’, implying material, and ‘mental/psychological’ and ‘social’, implying immaterial, on the other.

**Example, private practice.**

**I:** Is there a distinction you make between sick or not? So you have mental disorders of which we’d say these are afflictions where, you said yourself, you make a distinction between schizophrenia, ADHD, depressions, and so on. Adjustment disorders. Someone with schizophrenia is sick? That’s a disease?

**Psy:** Yes.

**I:** And ADHD?

**Psy:** Yes.

**I:** And depression?

**Psy:** That too...
I: All depressions?
Psy: No.
I: Where are the differences?
Psy: Well, the influence of the environment, the context. Like this woman who is clearly depressed by contextual factors and not simply and suddenly, boom, everything was fine and suddenly she’s depressed. So clearly matter-like.
I: But suppose, she’s experienced significant loss, let’s say, and has developed serious depression with all vital symptoms. What would you say then? Sick or not?
Psy: Yes, sick.
I: Then, you would? Why?
Psy: Because my concept of that is that there is so much wrong at neurotransmitter level and that might be caused by the outside world, but in the end there is so much wrong at brain level that I’d call it a disease.

Note that this participant allows for external, environmental causes of a disease concept of MD, but it is couched in terms of ‘outside world’, whereas the disease proper is located in the materiality of the brain.

Here an example of a more holistic, non-reductive perspective, from a psychiatrist in an institutional setting:
I: Are there areas of psychiatry you find philosophically interesting or problematic?
Psy: It’s hard to put it in philosophical terms but I am attracted to the discussion on pure biology or human functioning and I don’t just mean psychology since that implies such an opposition between psychology and biology. Human relationships I think are very essential. I’m not sure whether that’s philosophical.
I: But is it interesting or sometimes problematic?
Psy: Certainly interesting. Problematic, I don’t know.
I: Okay, we’ll come back to it, but maybe you can elaborate a little. Biological and human. You don’t put them in opposition but you do make a distinction.
Psy: No, I don’t put them in opposition. I see this as much more integrated. I cannot imagine the one without the other. I think it’s very reductionist to explain human behavior, human psychology solely from biological processes. On the other hand, I’m not esoteric like a human soul or spirituality. Not of that ilk.

Functionalism
This view of mind as a function of the brain was repeatedly implicit in participants defining disorder at the level of (societal) dysfunction whilst holding that such functions were supervening on brain activity. A small number of participants further developed such reasoning.
Example (academic):

**Psy:** I view psychiatry as a medical profession in which natural science is clearly central. This means that I think, when I’m talking to people, of functions, functions of an organ, the central nervous system. If that isn’t functioning properly, as in depressed individuals, due to stress and prolonged exposure to external difficult circumstances, flow circuits develop in which certain brain areas are less active or overactive…. that’s my view. That is the medical approach to my profession. The function of the brain.

**I:** So brain, medical, functions, natural science, they all fit together?

**Psy:** Yes.

**I:** But just now you said, you can’t reduce the cultural-social. ... You also said it troubled you that currently, people only seem to think in a technical manner. You could say, that in psychiatry, a medical profession, an organ-based approach in which the brain is central, that’s the way it should be, a consequence of the fact you’re a doctor and that’s how you’ve been trained. A critic might say that’s a weak defense: the subject isn’t amenable to one perspective and I apply both the natural and human sciences. That gives me more valid knowledge on the subject. Simply referring to a role is a weak argument.

**Psy:** If through a human sciences approach, say by psychodynamics, I can help someone, I certainly will.

**I:** But equally you see natural science as more central.

**Psy:** Yes, that’s central in my thinking on my profession.

**I:** Why is that?

**Psy:** I think it’s primary, basic. The whole... I don’t see it all as separate from each other but I think it advances our thinking. A psychiatrist is a doctor pur sang. He takes man into account, his functioning in his environment, bringing existence back to... is the body healthy yes or no, what’s going on in the brain?

**I:** But a critic could say: if you look at it only from the natural science perspective, then values have no place, and you’d miss a lot.

**Psy:** That’s true, you would.

... 

**I:** To apply only natural science requires ignoring values or reducing values to facts.  
**Psy:** Yes, but really, I don’t see the divide. Not as sharply as you put it. Just look at what happens. As van Praag used to say: “The mind does not float over the water.” You can see materially what happens if you give someone a placebo.

Emergentism

Though many participants supported a non-reductive view of personhood and
certain aspects of disorders, only a minority couched this in terms of emergent categories.

Example (institutional):

**Psy:** I think in autism too. On the one hand, I'm against reification, but on the other, I do think there is something there. That there's something wrong with the connections and wiring in the brain.

**I:** Would you, from your perspective, say that you have a real disease by the tail here? That it manifests itself fundamentally at this level?

**Psy:** Whether that is true as a rule?

**I:** Yes.

**Psy:** Then the question is, has someone got real symptoms or real deviant behavior. Your question then is, can you always find that, if you want to know everything there is of neurobiology, whether I could always find something?

**I:** Well, I mean, it's a lot like that, but it's more like, since you say, you think there's something wrong with the connections. It sounds like that is the most important level for determining pathology. That doesn't mean to say there's nothing wrong at other levels but that this is the level you'd say: “Yes, that's where the problem is.”

**Psy:** No, that isn't the most important level. I once heard the comparison: what is temperature? If you describe that only from the perspective of the speed of air molecules then you're doing it in a basic, physical manner. But that doesn't tell you what we experience as temperature. I don't think one is more important than the other. I think you should take notice of both. Those two levels. And that both can be helpful in understanding and doing something. So meaning and the physical level.

...  

**I:** So there is something essentially immaterial?

**Psy:** Yes, that has to do with meaning. What it means for someone to run into something like that. It has consequences and emotions in everyday life. It naturally becomes more complicated. If you describe the speed of molecules you do not yet understand what temperature is. You miss something.

**Holism vs. atomism**

This denotes the degree to which participants view it as valid to see and treat phenomena (experiences, thoughts, symptoms) as things in themselves or as inseparable constituents of a whole person.

Example (institutional):

**I:** Okay, you say you need different perspectives. In other areas of medicine things may be clearer... you might be able to follow one perspective?

**Psy:** Maybe more than one. If so then you can take a more relativist stance, and
psychiatry is also...it can’t go without the whole-person approach. You don’t treat a
toe, or a liver, you don’t treat a brain, you treat a person. That’s related to the same
thing. There is a complexity to that which requires creativity to always see the whole
person.... I don’t want to imply others aren’t doing good things but I know
psychiatrists who work very biologically and spoke to people for three minutes,
practiced in a very technical way. I don’t want to work like that, I don’t enjoy it.

Example (academic):
The discussion has been on the participant’s general approach to intakes. He has
described that his initial focus is on getting to know the other person, to form a
relationship, and to see what that looks like.

I: What are you looking for?
Psy: I need to get a picture of people that I can work with, provisionally. How the
matters lie, how things will probably go. I get a kind of a concept of what the
interaction is like, this person’s place in the world, what kind of person he is. Once I’ve
got that, I then view the disorder from this background and see what else pops up.

This sense of building a personal, holistic understanding, and using this as a
backdrop for specific exploration into lower-level phenomena such as symptoms,
complaints, and problems in the social domain, was a common occurrence (see also
Chapter 3). The exceptions in practice, were the practitioners predominantly
applying an actuarial approach. They motivated their approaches, however, from
the fact that the relevant help request was very limited (questions of
pharmacotherapy), entailing descriptive and actuarial modes, conforming to
previous findings of alignment.

Example holism as a starting point for exploration (institutional setting). The
intake is being discussed:

I: Yes, the first part is all experiential, then there is a medical part, and some
background. You see she sets things up and you follow. That does differ. Some
psychiatrists might pass that, but you follow. So psychiatrists handle that impact
differently. Here, some more client experience: “There’s a lot of anger inside you.”
Some more experience/psychology. You see a deeper explanation here too: “A little
like mother used to be...” That seems to concert drawing lines between the past and
the present. Her social situation, how old is she? A large part is directed towards the
person and HERE is the first place the psychiatric examination starts. Around the
middle of the first intake.

Psy: That’s interesting and I think that’s how I do it. I usually ascertain what kind of
person is before me and after that I see what the complaints are.
I: So this sequence is representative of how you work?
Psy: Yes, but now that I think about it, imagine if I was to explore the complaints very
technically, I assume it would be much more difficult to gain contact. I want to gain contact first, because if you do it the other way around then I’m in a kind of a technological mode and it becomes much more difficult to get the experiential side clear.

### 8.2.3. Interplay between ontology and practice

This category includes features of the conceptual interactions relating to how mental disorder is construed in practice. The features described here are closely related to processes described in the development of the DEF in Chapters 3 and 4.

**Plurality of perspectives on MD**

This indicates the idea present in participants that multiple conceptual and scientific perspectives are legitimately possible on mental disorder, either because there are fundamentally different philosophical positions possible, or whether multiple scientific perspectives are possible. Participants therefore differed in whether a unitary definition of mental disorder was principally impossible or just practically impossible for the time being (since science hasn’t yet shown us where nature’s joints lie).

The following example is further illustration of the harboring of multiple concepts of mental disorder without one concept taking clear precedence. Also, it shows a notable feature, namely that participants generally didn’t appear to possess pre-existing definitions or conceptualizations and responded with off-the-cuff reasoning on the subject.

**Example (academic):**

**I:** On mental disorder. Could you tell me, or explain to me, what that is?

**Psy:** You mean a psychiatric disorder? “Mental” to me is such a difficult word. A psychiatric disorder, I think, is a very complicated question. If it was up to me I’d prefer to see them as a normal disease like diabetes or a thyroid problem. I think that in psychiatric disorders a lot of emphasis is put on the fact that you’re a result of disposition and environment. A disposition that is sensitive to developing that, in combination with stressful circumstances, leads to that disease. In somatic disease that is also the case of course (in coronary heart disease for example and maybe in diabetes too). In psychiatric disorders, it is so remarkably present. That to me is very characteristic, do you know what I mean?

**I:** The emphasis on...

**Psy:** (interrupts) ..the results of disposition and environment.

**I:** What’s the difference then with your examples of diabetes and thyroid?
**Psy:** In coronary heart disease that holistic idea is a little neglected. Someone has a heart attack. Period. We of course see whether someone has a sensitivity to developing depression in his family, has someone recently passed away? Hocus pocus...depression! That complex aspect I think is characteristic of psychiatric disorder. But that's not an answer to your question of what a psychiatric disorder is. The question to me is very difficult because I'm not sure how much scope I have for answering. What do you mean by “is”?

**I:** Well, what you envisage it to be. If you can put into words what a psychiatric disorder is. As physicians, we are expected to determine whether someone is ill or not, and has a legitimate claim to health care or not. A right to days off work, or a benefit...

**Psy:** That brings you to a level in which you say, if you have a depression, you should conform to such and such criteria. Then you get to a very insipid definitional level.

**I:** For example, that a psychiatric disorder is what is in the DSM?

**Psy:** Yes, that's how we work. You could also say that a psychiatric disorder maybe... everyone can be rendered somewhere under a Gaussian curve and people with psychiatric disorders have as a whole no significantly different behavior than those in the middle. They're just a little more to the outside and that outside is, for another trait, the outside of another Gaussian curve.

**I:** So less of a qualitative and more of a quantitative difference? A statistical approach?

**Psy:** Yes. Quantitative and contextual difference. That is also important. Culture, the phase of someone’s life...

Within this excerpt, the participant mentions a simile to physical disease, a stress-diathesis holistic model, an ideal type model, a statistical model, and a hint towards a sociocultural model. Also, she is actively reasoning on the matter, demonstrating the fact she does not harbor any one pre-existing, developed conceptualization of mental disorder.

**Heterogeneity**

Though at first glance this theme strongly resembles the previous one, the difference is between epistemology and ontology. In this theme, the perceived heterogeneity lies within the phenomena themselves, rather than the epistemic perspective. In other words, pluralism refers to the presence of multiple concepts of MD in participants, without one single concept taking precedence. Heterogeneity refers to the concept itself, and its manifestations in practice: mental disorders are seen as ontologically heterogeneous, and therefore different conceptualizations of MD are (legitimately) applied to the same phenomena in practice. Of course,
pluralism and heterogeneity so described are related, nevertheless ontology does not fully determine epistemology, and discrepancies could be observed between ontological and epistemological positions. Participants frequently used the term ‘dysfunction’ to describe a demarcation criterion for mental disorder. However, a function can be defined in reference to different biological levels, e.g. brain, mind, behavior. Participants varied in a) whether they advocated a privileged level of (dys)function as demarcation and b) if so, which levels these were.

In this conversation with an academic psychiatrist, the participant mentions different concepts of disorder, both seen as valid:

I: What is psychiatric disorder?

Psy: I haven’t given it much thought. The question is whether people, when they’re sitting opposite to me, have a right to something. I do get it more at the other institution where I work, and I see less serious problems. Then, with some clients, gradually, I think, a first-line psychologist could have done this. Or I think people could have showed a little more resilience and coped with it themselves. I get that sometimes. But if you ask me this, the following thought arises: this society is a reference point for me and for everyone living in it. You look around you, in your own environment. There are a lot of problems in a personality disorder that can be traced back to interaction and emotion regulation problems. And the suffering seems to me to be realistic. I can empathize with that. Relationships, work, all sort of failures, being left with bad feelings... But I’ve never got the idea to think they should just go ahead and work it out themselves. On the contrary, that seems very unpleasant! If I was in such a condition...

This excerpt is representative of many participants, in there being different conceptualizations of mental disorder mentioned: biological cause, suffering, social functioning, and a sense of society co-determining what is legitimately within the domain, and also, in this case, a kind of ethical cognitive imperative: ‘If I were in such a condition...” Like other participants, this psychiatrist made a difference between different disorders in the way in which he saw them as disordered, but for a large part of the domain, this did not affect their legitimacy as a mental disorder. Towards the less severe end of the spectrum, there were doubts, which seemed to be handled through a form of empathy with suffering. A consistent finding in this study was the fact that participants apply multiple conceptualizations of mental disorder when assessing one patient.

This perspective also serves to explain the popularity of the ‘dysfunction’ concept for the participants: it functions as a linguistic carrier for epistemic and ontological pluralism, since ‘dysfunction’, as we saw previously, can be applied to all ontological levels, from the micro-material level to the social-adaptational levels...
and all in-between. This excerpt is from an interview with an academic psychiatrist who worked in chronic psychiatry, treating both residential patients and outpatients:

**Psy:** In essence I still don’t know what a mental disorder is. In the 15 or 20 years I’ve been working and working on my thesis... It’s certainly not the diagnosis. Diagnosis doesn’t help explain anything. I think there’s more of a hierarchy in my thinking. There’s a kind of dysfunctionality that is superimposed on the underlying suffering, the complaints, the problems. But the dysfunctionality in society, that’s more important than the complaints that people have and display.

**I:** You’re saying dysfunction in society, that’s the first thing you think of.

**Psy:** Yes, I think that if someone lives here then he’s already dysfunctioning socially, or he wouldn’t be living here. You see that in sheltered housing too... I mean, there’s all kinds of dimensions of social dysfunctioning. I have a lot of people in my caseload who show dysfunctioning in society but are still living at home or together with their partner. It doesn’t make much difference for my approach, just the degree of dysfunctioning and suffering is greater.

This excerpt also demonstrates a possible effect of areas of experience and context in the psychiatrist: this psychiatrist has worked for some time in social psychiatry, in which in practice the criterion of social functioning is highly relevant for allocation decisions (as the psychiatrist himself attests to). Therefore, it is possible that simply by familiarity and due to its high pragmatic relevance, this concept of ‘dysfunction’ is most likely to be held by this psychiatrist.

In most participants, a plurality of concepts of disorder work in concert in the analysis, applying to various features of the encounter and the phenomena.

Example (institutional):

**I:** On the demarcation of mental disorders themselves. When do you call something a mental disorder? This person [the patient seen in the intake] has been home off work for quite a while, but with a little structure seems to be able to function reasonably well. When he’s with friends he cooks, he can enjoy that. He has a personality disorder NOS (in your report) and ADHD (also there) on the DSM. But if you look at his level of functioning, our impression was: this could be on the fringes. So do you think this should be in the domain of mental disorder? This was something noteworthy for us. Yes? No?

**Psy:** Yes, he’s a man who, well, he’s doing all sorts of stuff in it [this is a Dutch psychotherapeutic colloquialism denoting psychodynamic or systemic interplay between patient and therapist, e.g. transference reactions], and that’s often the case in mental disorder. He’s very unhappy, he has suicidal thoughts and is very panicky and he can be so unhappy because he’s alone and then sits on the couch all day. He
has serious debt, the rent, bills haven’t been paid. So, yeah, the question is, what is a mental disorder then?

I: That’s one way of looking at it. You could also say: “What are the things in practice that drive you to say: this person should be taken into treatment, we let him through the gate?”

Psy: In the first place, this has to do with the fact that there are psychiatric symptoms. That’s the beginning. Those can be voices, depressive complaints, passivity, but, to this is added that someone is suffering from them, can’t handle them and they hinder them in living a meaningful life. These are all involved. Then it is even more important whether you take someone into treatment. I think many people up to this point haven’t really been motivated or aren’t ready for psychiatric treatment. Whether that’s medication or a psychotherapeutic treatment. That. I think, is a very important criterion. If you say people have symptoms that trouble them… suffering, being troubled… that probably goes for 30% of the GP population. Then there is a further consideration: is someone ready to change, to relate to himself in a different manner, to try different behavior. Being ready to take medication… that is another factor.

I: You might say this is a pragmatic criterion.

Psy: Yes. People need to be in a place to do something with us.

Pragmatism
This is the idea that rather than having one or more concept of disorder determining and demarcating the domain of mental health care, the pragmatic utility of the help offered in relation to the presenting problems is determinative of designating such problems as mental disorders. In this way, the concept of disorder is more a result of practices than their determinant. Different possible concepts can be chosen, but what drives decisions is an ethical and/or scientific idea of a good way to proceed, and the concept follows from this. The pragmatism applied by participants relates to benefit framed in terms related to mental health. This may be in a narrow medical sense of reduction of symptoms and complaints, or may be framed in a wider social sense, or in relation to psychotherapeutical notions, depending on professional values, role definition and local institutional context (see also Chapter 3).

In the following excerpt from an interview, a psychiatrist working in an institutional setting legitimizes a pragmatic view of the concept of disorder and discusses pragmatic practical conceptualizing.

Example (institutional):

I: Is it usually clear to you how you distinguish disorder from non-disorder?

Psy: No. As soon as I see someone the first time, I still have an idea, but if I’ve spoken
to someone three or four times, then I’ve lost it.

I: There are black and white situations, like evaluations for involuntary admission, do you have a model for those?

Psy: Yes. You enter into such a situation, and then I think, intuitively: this isn’t going well, if someone continues to walk around, for himself or for others, then I have to say, and I have a certain skill in writing it down in such a way that everyone thinks: yes, that’s logical. I have a certain proficiency at that.

I: So in fact you work from a very pragmatic principle.

Psy: Yes. I find a language to do what is best.

I: That does imply, if you want to remain consistent, that you don’t have a very hard naturalistic or essentialist model of mental disorder, in the sense of a broken leg is a broken leg, the way you put it is much more malleable. Depending on the goal it’s broken or not, I’ll focus on how I can relieve someone’s pain. If I have to give it some other name, fine.

Psy: Yes.

I: This kind of pragmatism is criticized on the point, that it isn’t objective, or scientific. You could medicalize social problems, for example. Paternalism. How do you defend it?

Psy: It works!

Pragmatism is not limited to what is deemed effective in treatment. There is also sensitivity to pragmatic roles concepts of disorder can play within society. In this excerpt with an academic psychiatrist, the discussion was on dealing with demands from patients for certain treatments:

Psy: It depends on how they handle their responsibility, and whether they come to me for a magical solution.

I: And if they want it they can get it then?

Psy: Yes, if they’re adamant, the more desperate they are and the less coping resources they have, the sooner I’ll give in. But their claim also plays a role. I can’t have big arguments all day.

I: That’s understandable. Before you know it they’ll be calling you dr. No.

Psy: The whole societal development is involved in this. There’s so much attention to the biological, to ADHD, to manufacturability of the self.

I: What do you mean by the biological and ADHD, what’s the relation there?

Psy: The manufacturability I think. People have gotten the idea in recent decades that quality of life can be manufactured by something outside themselves.

I: But you use the term in relation to ADHD. What’s the association with that?

Psy: Because I see it a lot there. A great many adults are completely convinced they have ADHD. While my idea is “No, unless...”, for them it’s often “Yes, why not?” Yes, unless...
I: You connect the idea of having a certain affliction and there being something you can do about it, and that something is external.

Psy: Yes, and in ADHD I think there is a lot of externalization.

I: So someone who sees it like this doesn’t actually see it as something of their own? It’s part of them but not their own self?

Psy: Yes, it’s part of themselves, but it alleviates them of the responsibility.

Pragmatic thinking has consequences for the estimated relevance of mental disorder conceptualization for demarcation and suits a dimensional, ‘grey area’ view of the demarcation between disorder and non-disorder.

Example (institutional):

I: So you use a Stepped-Care Method. Now the question arises, how do we demarcate what does and doesn’t belong to the territory? You can view that pragmatically. But critics then say that anyone who might want something or thinks they might improve, would be welcome in psychiatry. It’s too weak of a border. It medicalizes and leads to overspending on psychiatry.

Psy: Yes.

I: It depends too on whether you say pragmatic thinking is just the pragmatism of the interests of the patient or whether you take pragmatism more widely, in the interests of society as a whole.

Psy: Yes. Those are all factors that are involved I think. We’re pragmatic in the sense here that our ‘Front door team’ takes people into care but doesn’t immediately allocate them to ‘psychiatry’. Even if we are a mental health care institution. I’m convinced that a sharp boundary isn’t necessary to help people well. So keeping the stepped care approach in mind, where possible with light measures, more psychological/supportive and where necessary gradually scaling up to a more biological-psychiatric treatment.

I: So in fact you’re conceptualizing in a dimensional manner and the ‘Front door team’ is a link somewhere on that scale, where it isn’t psychiatry, but it isn’t nothing either, it can still go either way, it’s in the grey area.

Psy: Yes. Let’s just have a few sessions with this client.

Context-dependence
This denotes the fact that different conceptualizations of mental disorder are applied in different situations, and in relation to different ends.

Example, private practice:

I: .. Psychiatry has to offer some rationale like: “No, this is really real.” Suffering is one component, but there is a lot of suffering in the world and only part of that should be
seen to by psychiatrists. What’s the rationale for that in your view? Something that motivates: “That’s why it’s my domain!”

Psy: Yes. A mental disorder. I’ll do it like that. Relationship problems, is that a mental disorder? Doesn’t automatically follow.

I: Is it good enough for you, to say: “If it’s in the DSM, fine!”

Psy: Yes, I think so.

I: Would you write out a section notice for involuntary admission for all disorders in the DSM, if they were causally linked to a danger?

Psy: No, I don’t think so.

Another example, from private practice:

I: Have you ever had problems with the demarcation between mental disorder or not? That it troubled you?

Psy: Like the example I just gave, the patient with putative ADHD. I told him: “You’re not sick, but you might benefit from talk therapy.”

I: Wasn’t that a quandary for you?

Psy: I didn’t see it as a quandary. Well, maybe a little, but not to the degree that it weighed on me. But it was a bit of a quandary.

I: So it’s like: “I may be going slightly off-boundary, but if I don’t do that too often…”

Psy: Exactly.

... Another area people see as challenging, is that of involuntary admission and compulsory treatment in psychiatry. Which is legitimized on the basis of mental disorder. And as a psychiatrist you do such assessments. How have you handled the demarcation there?

Psy: I can handle it in the sense, that it relates to someone with such a disruption in thinking and behavioral phenomena that he is incompetent, incapable of judging what is good for him or for others and is also a danger. I can handle that quite easily. Once I saw someone who was psychotic, had been arrested by the police for bothering people. I found out he’d been badgering people for money. It had nothing to do with his psychosis but with his antisocial personality disorder at that time. So I didn’t section him.

Context-dependence is connected to pragmatism. The kind of criterion set for ‘mental disorder’ may differ in different therapeutic settings, e.g. between voluntary and involuntary treatment, general polyclinic or a dedicated psychotherapeutic setting, general intake versus a ‘narrow’ psychiatric examination. The aim of the medical treatment is involved in the assessment, since
there is knowledge of what kind of treatment will be on offer, and part of the assessment involves judging whether this offer would suit the problems at hand.

Example (institutional):

_I:_ Your intakes were different. One was a psychiatric examination, the other an assessment. If you, in your practice, get asked to do a psychiatric examination and you set that against a general intake, what are the differences between those situations?

_Psy:_ If I get someone for a general intake then I try to look very broadly, to take in different perspectives. To take in both biological and psychotherapeutic perspectives. What could benefit this person? This I try to take along. Once the intake is done, then I try to see from what perspective it has been viewed. Then I can narrow myself down again. Usually this means I’m seeing what can be done, whether medication is necessary.

_I:_ What does that perspective, whether medication is necessary, entail?

_Psy:_ The emphasis lies more on the axis I, on the psychiatric state. Whether the emphasis lies there or whether it’s a coping style or a personality problem. If it’s more psychiatric state, then to define it in such a way that you have an argument for pharmacotherapy.

From this example, we can derive that in the example of the psychiatric examination, the concept of disorder invoked is limited to axis I disorders and the possible beneficence of medication, whereas in a general intake a wider array of perspectives (and their allied mental disorder concepts) is applied.

Practical Integration

This is how the above features are handled in practice, and is a link to Theme 1 (Diagnosis and Classification). This category cannot adequately be illustrated with excerpts since it is a higher-level category explaining the operation of abovementioned categories in concert, and is also described in Chapter 3. It is, however, important to distinguish this category, since this does describe the manner in which psychiatrists not only access different conceptualizations of mental disorders cognitively, but also explore the phenomena in the intake from the perspective of multiple conceptualizations, sometimes prompted (based on the ontological potential of the phenomenon plus alignment), sometimes based on top-down penetration. The final decision to deem the phenomenon as an exemplar of the mental disorder concept, is, insofar as it is consciously made, based on a weighing of multiple conceptual sets, and a result of the DEF process. Rationality is explored in a search for meaningful understanding in the psychosocial domains. Understanding includes non-rational, empathic understanding. Degree of suffering
is noted, and degree of dysfunction over multiple ontological levels, depending on the phenomena (biological, psychological, social). To determine dysfunction, many participants require meaningful context. These three factors are supplemented with the more general ontological understanding of the phenomena, either at symptomatic or at syndromal level, as more or less material. Causal dualism is another relevant factor here.

Relevance
The degree to which the demarcation problem is experienced as relevant and/or as a problem for practice. This is rarely the case, as generally there is no conflict of interest between patient and psychiatrist in the sample here. Integration under one concept is not generally seen as a practical requirement as (pluralist) piecemeal approaches to lower-level phenomena are frequently undertaken, e.g. to symptoms, relationships, psychological difficulties. Participants noted the relevance of a concept of disorder (or, as we have seen above, multiple concepts) as a general reference guide, however, there was generally little necessity for them to consciously refer to such a guide in the outpatient settings examined. For most participants, the legitimacy of entering into a treatment contract with someone who has come to the office voluntarily seeking help, is rarely questioned. The concepts of pragmatism, fulfilling, or being suspected of fulfilling, descriptive diagnostic criteria, and a notion of severity of suffering are sufficient not to entail debate on the legitimacy or not of the patient being treated within psychiatry and by a psychiatrist. Psychiatrists did note, and had experienced, situations in which such issues come to the fore directly in practice, especially in evaluations with regard to involuntary admission, or forensic psychiatric examination. In many other cases, dysfunction or distress are seen as self-evidently legitimizing treatment, which is, meaningfully, voiced in terms of ‘help’, which in Dutch language can convey a professional sense of ‘help’ as treatment or care. It equally invokes an ethical sense of duty.

An illustration of the transparently obvious nature of ‘help’. This refers to an interview with a psychiatrist working at the polyclinic of a large institution. He previously worked on a closed crisis unit.

*I:* When is there a mental disorder present, what are your views on that?
*Psy:* How I see that. Well, firstly, I don’t have to see that because someone has already been referred to the clinic.
*I:* Yes, but sometimes people are referred back. Think of the neurologist who writes:
'no pathological findings in my domain'.

**Psy:** Yes, but the way I see it... if someone is severely psychotic then that doesn’t necessarily imply that they should be admitted. Because if there are enough carers around him and there’s no aggression then he can be treated at home. But how do I make out whether someone’s ill? I guess by common sense.

**I:** I see. But how is that cashed out? Do you mean: I’ve seen so many sick people, I can recognize when someone’s ill?

**Psy:** Yes, I think common sense and also, because I’m a specialist something extra because I’m there, not just to determine whether someone has a disease, but to treat this disease. And that’s what I want to do. Simply treat and protect if it’s necessary.

This excerpt demonstrates a lack of a clear definition ready to hand for this participant, instead, there is a clear sense of a professional duty to treat and to protect. This may point toward the presence of moral emotion as a non-conceptual component of the decision to admit phenomena to the domain of psychiatry. This is illustrated later in the discussion:

**I:** You can have degrees of severity or suffering in disorders, which might be relevant to issues of responsibility or protection. Can you say which things are there that tip the balance in the one or the other direction?

**Psy:** Acting-out behavior, say with reference to a borderline personality disorder for example, if someone’s threatening to kill herself, then that’s something I can’t always judge correctly. Even if there is no psychiatric state I still have trouble with it.

**I:** Trouble with what?

**Psy:** Sending someone like that away.

**I:** Okay, so if you were to say "I’m leaving from the premise that this is behavior that someone can control, let’s say that this to you implies that someone’s not psychiatrically ill to such a degree that there is a kind of lack of capacity, with that kind of behavior you still doubt whether someone has total capacity, and whether you can actually take someone to be fully responsible for their behavior.

**Psy:** It touches my emotion there, as an individual citizen, not as a specialist. Because if a passer-by were involved he would say, this person, with this personality, is crazy. Because she wants to kill herself. She should be admitted and then afterwards you can discuss with your colleagues whether an admission is wise and helpful. That’s the kind of situation which I find very difficult.

The lack of clarity related to the boundary problem led to one participant making an ethical decision not to practice in one specific area of psychiatry. This excerpt

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21 “Geen bevindingen op mijn terrein,” is a well-known and well-worn medical phrase in Dutch medicine denoting a lack of diagnostic findings specific to one speciality e.g. no neurological abnormalities, no dermatological pathology etc.
from the interview with a psychiatrist in private practice follows a discussion on the concept of disorder in which the participant has professed to an idea of adequate functioning, stated primarily in social, adaptational terms.

Excerpt (private practice):

**I:** Do I understand correctly that you make a connection between functioning and a human norm of behavior, of what we can approximately expect of what is rational and reasonably adequate in certain circumstances?

**Psy:** Yes. I can call an animal crazy too. If an animal isn’t doing what is normal given what is the normal range of behavior for an animal then I judge my cat to be crazy.

**I:** So you define it at the level of behavior. Then there’s the two worlds we’ve been talking about, the client’s world and the more lawfully-driven world of nature, physics based on neurotransmitters, there are lawlike relationships in there. And functions then refer more to laws. So, an apparatus works in a certain way and you can expect it to have that function and if it doesn’t then there is dysfunction.

**Psy:** Yes.

**I:** And you say: well, my criterion for disorder is dysfunction.

**Psy:** Yes.

**I:** How would you place this dysfunction in a lawlike framework? Or let me put it this way, the framework of behavior, is more normative. It has to do with broad norms for behavior. The norms we have in our civil laws, for example, are not based on physical laws. It’s what we expect in a certain situation, a given context.

**Psy:** Well I have a lot of troubles with that normative feature then.

**I:** What kind of trouble?

**Psy:** That I think, well yes, that’s just my own perspective.

**I:** The relativity of your viewpoint. And what is your trouble with that?

**Psy:** I have troubles with filling in very limiting scales by which you put someone in a small box. Whether someone has capacity, for instance. I tend to think: who am I to judge. It’s so normative.

**I:** Yes. And to you this means that you have problems with applying your own norm to someone else. Which might have something to do with power.

**Psy:** Whether you commit someone involuntarily, or whether they are put in seclusion.

**I:** In those kinds of situations when it comes down to it, then it can be very difficult, because you have to make a very sharp, and very fraught decision on the presence or absence of dysfunction or disorder. How do you solve that? How do you handle it?

**Psy:** Well, in practice I handle it by not doing that kind of work.

**I:** But the work you’re doing here, you’ll have to make a choice of whether to treat someone or not. And you’re the psychiatrist. So the fact that you take someone into treatment implies they have a mental disorder, or am I mistaken? There’s a margin
Chapter 8

there. How do you legitimize your action and your status as a professional delivering treatment?

**Psy:** Well, sometimes I find that quite difficult. But it’s less fraught. In that case it’s the person’s own request which determines, together with my deliberations of course and the test of the group and the profession, so I think I have them behind me, but still I think I could just fool them easily. I could describe it in such and such a manner and they’d agree. That I do find difficult.

This participant is sensitive to the ethical issues implied in the normative action of deciding on diagnosis and has acted upon it (also displaying subjectivism related to such a value choice). Also, she is aware of the potential for pragmatism or beneficence to slip towards paternalism, or at the worst, abuse. What is remarkable in these examples is that the participants locate their ethical sensitivity to the situation outside of their professional role, the first psychiatrist saying, “as a citizen” and the second saying such judgments are arbitrary (and therefore withdrawing from its practice). Definitions of mental disorder were insufficiently helpful to them, instead there was a more or less intuitive, or emotional, understanding of the ethical dimension of the situation present, but there was an insecurity as to their professional legitimacy.

### 8.3. Discussion

#### 8.3.1. The three themes: concepts of disorder, philosophy of mind, and interplay.

**Concepts of disorder**

The first theme, the content of mental disorder concepts, broadly conformed to the psychiatric-philosophical literature (Bolton 2008, Fulford et al. 2006). Nevertheless, it is enlightening to note where practice deviates from the literature. An interesting feature, for example, is the frequent mention of ‘suffering’ coupled with dysfunction, where based on the literature we might have expected ‘harm’, to conform to Wakefield’s influential analysis (Wakefield 1992). This may be a linguistic artefact, given that harm translates to Dutch as ‘schade’, which also may denote stronger concepts such as ‘damage’. This is a concept more referenced from the third-person perspective, in contrast to the first-person perspective of suffering. Together with the finding that ‘understanding’ in the participants was not just limited to rational understanding but also involved empathic understanding, this points to the importance of a first- or second-person perspective on conceptualizing mental disorder. In other words, the psychiatrist is not just observing phenomena and fitting them to a known category, but is also engaging with the patient and, within this engagement, assessing rational and
empathic understanding, which weighs in as a factor in grounding the validity of ascribing 'mental disorder'. With respect to Wakefield’s reference to evolutionary theory, this aspect was not mentioned, though adaptation to one’s social surroundings and life circumstances featured strongly. Given the fact that this might simply entail a conflict between the individual and society, this routinely was rejected as sole criterion (see Interplay).

The mind-body dualism already noted in Chapter 6 also featured here, as a modifier for autonomy: there was a tendency to ascribe limitation of volitional freedom to 'biological causes', ontologically seen as material. The mind, construed as immaterial is viewed as autonomous, but its freedom can be encroached upon by material processes. Interestingly, this encroachment is related to dysfunctional rather than functional processes: the material ‘underpinning’ or ‘substrate’ serves to set the conditions for a mind to be autonomous, and its (material) dysfunction therefore limits the mind’s freedom, according to many participants. The more phenomena are seen as biological (equated with ontological materiality), the less autonomous the subject is considered to be (and the sooner involuntary admission is deemed legitimate).

Philosophy of Mind
An emerging theme of this study was the importance of philosophies of mind for practice, a slightly unexpected development: what role could such highly abstract discussions play in practice? Philosophies of mind prove to be an important lynchpin connecting ontological and epistemological commitments to practice. We presented a psychiatrist who found room for his psychoanalytically-based practice by a form of dualistic interactionism, affording him a material reality base for disorder, whilst fully legitimizing attention to the mental realm. Conversely, we noted the presence of eliminative materialism providing a legitimacy for a preference for descriptive reasoning in practice. Most participants were antireductionist in the epistemic sense, allowing for legitimate psychological understanding (and treatment) of the mental, whilst combining this with varying degrees of materialism with respect to the ontology of mental disorder, offering a material, ontological legitimacy to the boundary question ('mental disorders are real diseases of the brain'). Of course, this leads to conceptual difficulties and logical inconsistencies (e.g. if all disorder is material, how can some disorders be more material than others?). Another interesting finding is the fact that practitioners’ generally (and understandably) only possess layman knowledge of philosophy of mind, whilst their implicit or explicit assumptions in this area can be highly determinative of practice: they determine the degree to which findings from
one domain (material-biological, psychological, social) become relevant to the other.

Interplay
The results may be sobering reading with respect to the importance of the concept of disorder in practice, and consequently, the relevance of philosophical analysis thereof. Firstly, we found that a general singular concept of mental disorder had low relevance for these practitioners. This finding is striking, as a main feature of the debate on mental disorder pertains to its function as a boundary-setting concept, determining domain legitimacy (e.g. Szasz 1961, Kendell 1975). Boundary issues seldom arose in the contexts examined here, meaning the qualifying function of the MD concept was rarely necessary. Many participants did have experiences in other contexts of care in which the demarcation issue was problematic, most prominently regarding involuntary admissions and the related curtailing of personal autonomy. One explanation for this may be that boundary conflicts on disorder are far removed from day-to-day practice. The treatment setting we examined was a voluntary one, and in this setting, the main participants may have low incentive to challenge the legitimacy of this encounter: this has already been established through institutional means (e.g. referral by the GP). The act of entering this domain is less contested than that of involuntary treatment and hence, the concept of mental disorder does not attract the attention that it does there. Fulford (1989) cites Austin (1956/1957), noting that ‘the negative concept wears the trousers’, in other words, it is where problems and conflicts occur in practice that we are more likely to become aware of conceptual complexities and it is just in these areas that empirical examination of ordinary language is fruitful. Here, daily practice is relatively untroubled by boundary conflicts on this issue. Meanwhile, there is awareness of the demarcation problem of MD in society generally, apparent in comments alluding to societal processes influencing the way in which patients access mental health care, issues of medicalization, market forces, etc.

With respect to the constitutive role of MD concepts, plurality and heterogeneity featured strongly, implying a lack of a singular, consensual definition of mental disorder (unsurprising in view of the extensive literature on this subject) at group level, but interestingly also at individual participants’ levels. Participants employ multiple senses of mental disorder in practice, and in fact, they apply multiple conceptualizations of mental disorder within one encounter, as may be seen from numerous examples in the results. These findings accord with the literature pointing to the presence of ontologically heterogeneous conceptualizations of mental disorder in practitioners (Ahn et al. 2009, Miresco & Kirmayer 2006). They
are also consistent with approaches to the conceptualization of mental disorder from pragmatic and pluralist perspectives, viewing mental disorder as a disjunctive category based on the ontological diversity of its causes (e.g. Maung 2016, Kendler 2012). Furthermore, participants applied different concepts of mental disorder to exactly the same phenomena, displaying multi-perspectivism at the phenomenal level. At face value, this ‘application’ of mental disorder concepts seems relativistic, whereas we may desire our concept of mental disorder to possess some foundational, legitimizing weight. However, the ‘Interplay’ category is crucial in understanding the ontological prompts, potential, scope, and alignments that phenomena elicit, implying that the conceptualization of disorder in practice is no eclectic free-for-all.

To illustrate, let us take a hypothetical encounter as an example, and return to the DEF-model developed in Chapter 3. In this model, the patient displays/produces phenomena, which in themselves carry a certain ontological potential, and ontological scope, which affect their perception by the psychiatrist (‘bottom-up’ effect or ‘prompting’). The scope and potential both imply limitations, engendering cognitive command: if a patient mentions feeling depressed to the psychiatrist, the latter would be mistaken if he noted that the patient had not expressed this fact (cf. Jaspers’ views on objectivity). Within the phenomenon of ‘feeling depressed’, however, there is much scope for interpretation. The immediate perception and subsequent interpretation in the process of the DEF is also affected by the repository of theories and related categorizations available to the psychiatrist, under which the phenomenon can be categorized (‘top-down’, ‘import’). The themes described in the ‘second level’ of diagnostic work further shape and constrain the ongoing conceptualization of disorder within the encounter, whilst scene-setting features such as the primary ‘help request’ on the part of the patient, and the institutional settings (material and immaterial) further demarcate the range of conceptual possibilities. Though there is scope for variation in these connections, they are not arbitrary.

In this example, we will examine several phenomena produced during the intake, for sake of clarity we will classify them into Groups A to C. Groups A and C are phenomena with strong ontological potential and narrow ontological scope. These are phenomena that tend to be associated strongly with a single ontology (material vs. mental), based on the personal/professional repository of (causal) theory connected to these phenomena. Thought insertion is an example: this phenomenon was long thought to be emblematic of schizophrenia, and to be associated with severe, biological mental disorder. Group A in this example consists of such narrowly material phenomena. A week-long grief
reaction to a loss would be an example of an ontologically ‘strong and narrow’ phenomenon connected to a psychological explanation/ontology, here allotted to Group C.

Group B contains phenomena with weaker potential and wider scope. Examples here include a wide range, e.g. feelings of depression, sleeplessness, obsessive behavior, anxiety, avoidance behavior, etc. Such phenomena are amenable to reallocation to Group A or C after further examination, depending on which phenomena they are associated with, and what -if any- explanation they are connected with in the DEF.

How does this work, if we follow the practices in this study? When an intake commences, the ‘internal DEF’ starts developing. The participants note the phenomena and select one or more for further exploration. We will run through a few scenarios to obtain a sense of how this proceeds. We expect group A phenomena to elicit descriptive mode questions (prompting), and Group C to elicit meaningful mode (through ontological alignment). However, no practitioner limits herself to one mode of questioning.

Scenario 1: the psychiatrist is on call in a general hospital and called to a recently admitted patient who has become increasingly agitated, has clouded consciousness, and seems to be hallucinating. This combination of symptoms (recall that a ‘phenomenon’ as described in Chapter 3 may also be a combination of symptoms and signs) elicits the concept of delirium in the psychiatrist, who explores descriptively, discovers from the file that the patient was previously known to be addicted to alcohol and adds the explanation ‘alcohol withdrawal’ to the DEF. At this point a, the phenomena, explanation, and ontology of the disorder of this patient are all firmly within Group A, and of a primarily material nature.

Five minutes later, the patient’s wife arrives, and the psychiatrist takes this opportunity to gain additional information. She says the patient had recently been in treatment for his alcohol addiction, and had been successful in achieving sobriety and maintaining it. She adds she has seen this behavior before, in the year her husband returned from active duty in Iraq. He would wake up at night in an agitated state, and she would have trouble achieving contact with him.

This information is grouped together at point b by the psychiatrist as ‘possible PTSS and dissociative state’ and added to the DEF. For this psychiatrist, this complex phenomenon is now connected to a broader, group B ontology, now integrating external (traumatic) causal features and mental (flashbacks, dissociation) phenomena. At this point the psychiatrist is holding plural explanations in mind with different ontologies, both seen as valid ways of conforming to ‘mental disorder’, but for this to be so, plural definitions of mental disorder must be permissible. This feature of plurality entails that we would expect
this psychiatrist, if asked at this point, to produce a *broader* set of concepts of disorder as relevant than at point a. The high ontological potential and narrow scope at point a would, we expect from the effect of alignment, predict the psychiatrist to point to the material-biological concept of disorder as relevant to the case, whilst at point b, a functional/adaptational concept, and possibly one of suffering, would suit the causal theory. Both plurality (the psychiatrist holding different concepts of mental disorder) and heterogeneity (mental disorder as a group being ontologically heterogeneous) are featured here.

The applicable concepts in this example would depend in part on the relevant explanatory theories on PTSS (these include social, psychological, and biological theories) brought to bear on the phenomena by the psychiatrist. PTSS, therefore, has a wider ontological scope than delirium, and this allows for more ‘top-down’ influence from the theories and concepts held by the psychiatrist. The point here is that such conceptualizations of disorder are connected to phenomena in practice in a piecemeal and localized fashion. They may be connected to a singular phenomenon, as in the example above of thought insertion coupled with a material-biological explanation, or with more complex phenomena, such as a taxonomic concept such as PTSS, but are also associated with concepts derived from different theoretical and etiological approaches such as narcissism, attachment issues, the identified patient, to name but a few. As we saw in Chapter 3, the DSM does not have privileged status as a conceptual diagnostic system for the participants of this study: theoretical pluralism implies multiple theoretical perspectives on phenomena and therefore, multiple ways of apprehending and naming them. In other words: the final ontological status of the DEF at the end of the encounter depends on ontologies derived from multiple theoretical sources beyond DSM. As these theories are embedded in professional and scientific communities, these constrain the pragmaticism of the practitioner, acting through theory, professional institutions, guidelines and suchlike.

In a second scenario, a psychiatrist is speaking to a patient in an outpatient, private practice setting. The patient has complained of feeling depressed, tired, having trouble sleeping, being irritable and impatient, and having lost weight recently. For the psychiatrist, taken as a whole these phenomena have low ontological potential and a wide scope (Group B). As the psychiatrist has psychodynamic affinity, she explores a number of familial and work relationships and notes the patient’s attitudes and behavior as he describes them. A psychodynamic explanation forms on the part of the psychiatrist, in this case, one of narcissistic injury, and the psychiatrist, through a subtle addition to the summary, adds this explanation to the DEF (a). The patient, however, rejects this explanation and suggests that he could
be suffering from a depression due to a lack of serotonin in his brain (b). The psychiatrist descriptively explores symptoms of depression and concludes that the patient fulfills the DSM-criteria for depression, which she tells him. She also concludes that this patient is unlikely to benefit from her kind of psychodynamic approach to treatment, and decides not to challenge the patient’s explanation. She starts him on antidepressants. In her succinct letter to the GP the diagnosis is given in descriptive terms and the DSM classification is noted.

In this example, the wider scope of the presented phenomena allows for the presence of two different explanations (and connected ontologies) of the phenomena, one favored more by the psychiatrist, the other by the patient (heterogeneity). The psychiatrist reasons from theory that it would not be possible or beneficent for the patient to continue arguing for her favored explanation (note that she does see both explanations as valid, demonstrating explanatory pluralism). She reasons pragmatically to conclude it would be wise to follow the patient’s perspective. The final (at least at the end of this exchange) conceptualization of the mental disorder in the ostensive, shared DEF is material (though the psychiatrist carries a more heterogeneous view), and the result of an ongoing process in which phenomena are interpreted and reinterpreted, limited on the one hand by scope and potential, on the other by institutional constraints, but open to interpretation and reinterpretation based on theoretically informed understanding and value-driven pragmatism and interests.

The example illustrates the conscious, pragmatic application of an explanation (connected to a mental disorder concept) within Group B phenomena. As we have seen previously, it is just the lack of available singular etiology that in the views of many participants legitimizes explanatory pluralism, and psychiatrists actively apply different conceptualizations pragmatically to further therapeutic purposes. However, this perceived general lack does not imply that there are no causal ontologies (hypothetically) connected to the phenomena in practice: both this chapter and chapter 3 show evidence of the presence of causal, ontological associations with the phenomena on the part of the psychiatrists, narrowing the ontological scope of the phenomena and thereby limiting the space for either eclecticism or pluralism. In this latter example, pragmatic and value-related considerations affect the development of the DEF and hence, the ontology of the mental disorder as it is understood within the DEF (note that in this instance the ontology of the shared DEF deviates from that held by the psychiatrist). Plurality, heterogeneity and pragmatism are active. The ostensive conceptualization of mental disorder in the DEF is material, but from the perspective of the psychiatrist it is, at least to a degree, pragmatic. The use of DSM terminology in notes to the GP
was repeatedly motivated on pragmatic grounds by participants as required for access to reimbursement. This conceptualization then has been constituted in a pluralist fashion, partially via family resemblance/ideal type modeling, and partially from pragmatism. This illustrates context-dependence: in the context of the requirement of a DSM-diagnosis in a written report for reimbursement, this is offered, adding a different MD concept.

To extend this second example of a set of Group B phenomena, the same patient instead is seen by a psychiatrist who has affinity with cognitive-behavioral treatment. As the DEF develops, the psychiatrist explores the patient’s set beliefs, coping behavior, and a number of situations in which negative cognitions and self-defeating behavior are elicited. The psychiatrist offers a summary in the DEF with CBT content, which the patient rejects in favor of the ‘missing neurotransmitter’ explanation. The psychiatrist explains that such a lack is a manifestation of a depression, which can be caused by stress and life events affecting brain functioning and thinking simultaneously. The patient accepts this explanation, and a dual-track treatment follows where the patient receives both CBT and an antidepressant.

In this example, we see pluralism in place again, in this case, pluralism concerning the same phenomena. Though causal dualism may suggest phenomena to be viewed in terms of being either materially or mentally caused in a dichotomous fashion, in practice we observed practitioners viewing phenomena as being plurally determined. The relationship was dimensional: the more a phenomenon is seen as being biologically determined, the less psychosocially determined it is. Like we observed in the study, plural explanations are in place, and each is aligned with a treatment with an aligned ontology. This also demonstrates the potential effect of current and past institutional top-down effects: had this psychiatrist trained at the same institute as the previous one, her affinity may have developed towards psychodynamic theory.

These examples illustrate the action of mental disorder concepts in practice as developed from our study. The concepts prove to be both cause and consequence: they are elicited by the ontological potential of phenomena, but also shape the content of the DEF, in the process affecting the ontology of the explicandum. Therapeutic and explanatory pragmatism are entry points for values, as are the constraints of the help request and the institutional effects. To put it differently, referring back to Chapter 7, it is possible for the practitioner to get both factual and evaluative aspects of the encounter wrong.

Obviously, the grouping of A, B and C phenomena is a simplification, and we expect
the ontology of phenomena to vary on a dimensional rather than a categorical scale. The room this affords the practitioner to apply different explanatory models, either from affinity, for pragmatic purposes, from a negotiation with the patient, or through other creative actions, means that for these practitioners, the demarcation problem is very rarely an issue. The psychiatrist, as one of our participants noted, is capable of choosing the right words to ‘do what needs to be done’.

This may seem at first glance a relativistic conclusion, suggesting an unacceptable degree of freedom for the participants in the encounter to construct a diagnosis for whatever pragmatic ends. In other words, there is a danger of a lack of cognitive command, and practitioners would not be capable of errors of diagnosis or judgment. This would constitute a threat to their claim to privileged knowledge. However, we should not lose sight of the degree to which MD concepts within this model can be and are determined by the phenomena, as in the first example, through prompting, their ontological potential, and alignment. If the practitioner is operating in a society in which the DSM classification is a required element of the diagnostic process, and she fails to identify DSM-related phenomena that are present in an encounter, this is an error according to the epistemic scheme within which she is operating (recall the constraining role of scientific communities noted in Chapter 7). The model, however, does not presume one privileged taxonomy or categorical set a priori.

It is also important to remind ourselves of the constraining professional actions described in Chapter 3, where clinical and narrative reasoning are tied to both nomothetic clinical and actuarial knowledge and to hermeneutic processes involving continuous interpretation-checking with the subject him or herself. This draws our attention to an alternative to a conceptual/definitional foundation for legitimacy, namely an ethical one: good professional practice. This implies more emphasis on a pragmatic understanding of disorder, along the lines of Bolton’s suggestions (2008): where the specific answer to certain problems is seen to be individually/scientifically advantageous, this functions as a demarcation of the domain. The degree of pragmatism evident in this study, not only with respect to mental disorder, but also on issues of science and diagnosis, necessitates a rethink of the role of values in grounding the profession’s legitimacy.

Another consequence of the scope practitioners enjoy in applying pluralism and pragmatic normative considerations is that it may lead to objections from an ethical perspective: if there is no firm conceptual basis for mental disorder, by what right may the professional legitimately reduce another’s autonomy? In an example noted in the results, this worry was sufficient for one practitioner to decide not to perform evaluations regarding involuntary treatment. Such worries may be related
to a position of values subjectivism: ‘Who am I to make such decisions?’ As described above, one’s position on the possible foundational role of values and value judgments is crucial in this regard (cf. Sadler 2005, Thornton 2007). This is also an example of Woodbridge & Fulford’s question: ‘Whose Values?’ (2004) which draws attention to the necessity for good (democratic) process if such questions are asked of practice. This issue will be examined further in the general discussion in Chapter 10.

The way concepts of mental disorder appear to feature and act in practice differs from conceptualizations of mental disorder in philosophy of psychiatry. In the latter, there has been a long tradition of aiming for a singular conceptualization for mental disorder to cover all cases in all circumstances. Whereas the plurality of concepts of disorder in practice might be taken in a negative sense to imply confusion, a different conclusion might be more apt: practitioners may be sensitive to the contextual demands of different situations: as we saw in Chapter 3, phenomena elicit different causal/ontological interpretations, and are linked to different theoretical heuristics, from all the main domains, biological, psychological, social. It is entirely fitting with this approach to understand that phenomena may be ‘mental disorders’ in different ways, through purported biological dysfunction, disproportionate and dysfunctional reaction to stress, or irrationality. Also, the value-laden nature of disorder necessitates a meaningful context within which a judgment should be made. These considerations lead away from a singular, unifying concept. Given the heterogeneity displayed on so many fronts (scientific, classificatory, conceptual), the prospects for a single definition covering all instances of what we term ‘mental disorder’ are dim. This does not necessarily require us to limit ourselves to a circular instrumental definition (mental disorder is what mental health professionals treat/care for). It is possible that mental disorder is a disjunctive category, comprising phenomena of a different nature. Taken in this way, the concepts applied to different phenomena and their different conceptualizations as more or less biological, (ir)rational, or pragmatic constructs may be legitimately connected to the nature of these phenomena themselves, or to the situation at hand. In other words: even if we may not succeed in constructing a mental disorder definition that is valid in all circumstances, nevertheless disjunctive conceptualizations of disorder may still be valid based on their ontological and epistemological relationship to the local phenomena and context. Whether the practitioner has ‘got it right’ in her conceptualization of disorder is a matter for local judgment, even as its content is derived from both local and general (theoretical/professional/institutional) sources. It is the variety present across such contexts that makes the ‘concept of mental disorder’ resistant to one definition. Cooper (2007) has argued that the plurality of plausible mental
disorder concepts notwithstanding, it is too early to resign ourselves to relativism on the concept: perhaps combinations of disorder concepts may work out. The idea that multiple conceptualizations may be operating simultaneously in individual cases may indicate further exploration of this option is warranted. An argument might be made along the lines of causal pluralism: if we accept that there are multiple 'levels of explanation' at work in mental disorder, and there are apparently multiple causal pathways in play (at the individual level), then it seems defensible to argue that mental disorder conceptualizations that are associated with different ontological levels are relevant to this individual instance of the disorder. This does not imply relativism, since there is a connection between the phenomena and scientific causal hypotheses that are applicable. The process of diagnosis described in the DEF model provides a framework encompassing, possibly, different causal/meaningful constellations, all contributing to the amalgam of the final MD concept. The fact that MD conceptualizations are, to a degree, connected to certain ontologies, makes the presence of plural MD conceptualizations, in these circumstances, logical. The validity of such a concept would depend on the validity of the theoretical connections between the phenomena and theory, but the assessment of the relative weight of contributions from different levels within the individual encounter, I would argue, is a question of clinical judgment and expertise, as it is strongly connected to the development of the DEF.

The possibility that mental disorder is a disjunctive category has been noted (Kirk et al. 2013), but the added features here are the possibility of simultaneously active MD concepts linked to specific lower-level phenomena (lower than the level of a taxonomic concept or recognized disorder, e.g. at the level of symptoms or theory-bound phenomena such as ‘splitting’), whilst being responsive and relative to contextual demands. In other words, mental disorders can be validly conceptualized in fundamentally different ways relative to local contexts. Judgment of the validity of the categorization as mental disorder therefore can only be done in relation to such context, rendering debates as to the precedence of one or the other general concept of disorder of limited relevance (as our participants seem to intuit). The interactions and effects of value-laden pragmatic considerations affecting the DEF and hence, the resulting ontology of MD in practice, result in multiple entry points for values in this process. We have seen many examples of such considerations. Again, this does not imply some form of subjectivism: we can judge such considerations on their merits, in their particular context, through ethical reasoning. And as mentioned in Chapter 7, values may be taken as features of the natural world (Thornton 2007). However, the nature of the interactions described here perhaps requires a novel normative approach as the
action of values is at a deeper level than is commonly assumed: in the current literature, the role of values in theapperception of the phenomena themselves, if present, is seen as a distortion. I do not agree with this. In the practice described here, values in the development of explanations are defended on professional ethical grounds, mostly related to a sense of beneficence for the patient. Identifying, describing further and evaluating such complex interactions between value deliberations, apperceptions and descriptions, could prove an illuminating task for an empirical ethics approach (Widdershoven et al. 2008) and calls for further philosophical field work (Fulford, 1989).

8.3.2. Gatekeeping and ontology

Through a set of institutional and legal arrangements, each society constructs a certain sense of legitimacy for mental health professionals to treat and care for a group of people identified as suffering from mental disorder. Obviously, these arrangements are locally and historically contingent, and different institutions are invested with the gatekeeper role. As we saw in our historical review in Chapter 7, part of the effort of founding the psychiatric profession was directed towards a power struggle over the gatekeeper role in the asylum. The hard-won authority over domain gatekeeping has, arguably, if not been lost then been progressively weakened and transformed throughout latter decades: where the simple assertion by the psychiatrist that there was a form of insanity present, was once enough to legitimize not only voluntary but involuntary treatment, in latter decades, helped by the revolt against authority of the Sixties, governments have sought to gain more control over the domain of mental health, with an eye to balancing (conflicting) public interest goals: ensuring quality and span of care, whilst guarding against excessive or illegitimate expenditure. This as a logical consequence of and societal reaction to the expansion of psychiatry into the societal domain throughout the twentieth century. Political views will affect such arrangements. For the patient and the psychiatrist, these developments have generally lead to a third party functioning as a gatekeeper, be it governmental institutions, health insurers, or municipal councils. The question of interest then becomes: how does the gatekeeper define mental disorder, and what consequences does this have for clinical practice? We already saw in Chapter 3 that the gatekeeping role of the DSM-classification played a significant role in its adoption, albeit in a peripheral manner, in practice: no DSM, no pay. However, it is also this peripheral position attested to by participants that points to the fact that just because the DSM is a contractual requirement for reimbursement, it does not automatically follow that patients will therefore be subjective to a reductive, one-sided descriptive practice. To put it in the words of the features found in Chapter 3 (Level 3): the import of the DSM ontology into practice varies. The effects of third-
party legitimization were not explicitly examined in this part of the study, and will be part of the historical review in the following chapter.

With respect to gatekeeping, a stable understanding of what a mental disorder is, be it scientifically, ontologically, or linguistically, seems helpful as an anchoring point: hence the perceived value of the DSM classification in providing a common language and 'reliable' categories. For mental disorder however, this study suggests that the entanglement of factual and normative features runs down to the phenomenal level, and that relative degrees of fact/value-ladenness also vary across disorders: certain taxonomic concepts (e.g. schizophrenia, autism) are viewed as more factually laden (based on a form of causal dualism and relating the factual to the material), others as more value-laden (personality disorders, paraphilias). This implies that the seeming clarity and stability of the DSM masks an altogether more fluid practice, where DSM classifications are not only temporary markers of clinical phenomena, but also constituted to varying degrees by local value-related interactions. What the psychiatrists in the study are actually doing, is attempting to attend to the factual and normative elements of mental disorder within the (idiographic) context at hand, driven by the central tenet of their professional role which directs them to prioritize one central value: the betterment of the patient. Still, to those familiar with the histories of abuses in and of psychiatry, this may offer scant reassurance. The cast-iron biological pathophysiological concept that Szasz popularized still carries much attraction for those desiring clearer, and stronger demarcation. However, the position of this study is that demarcation is more a consequence of professional, social, and scientific communal action than of the force of definitions and conceptualizations (though they do of course feature within such action). This will be elaborated further in Chapter 9.

8.3.3. Disorder, judgment, and expertise
A recurring term psychiatrists used when motivating their decisions was that one of their main aims was to ‘understand the patient, person, or problem’. Now our first reaction to this pronouncement would be to relate it to hermeneutical understanding, to issues of meaning, all falling within Jaspers’ famous distinction. However, in my view this may not be the meaning of ‘understanding’ that is active in these situations, as Jaspers distinguished causal and meaningful approaches and applied the latter only to a subset of the phenomena present in practice. As we saw in Chapter 3, participants are constantly engaged in a process of exploration and individual validation: ideas, reasons, explanations, are constantly being summarized, checked, reflected back to the patient. All the examples of psychiatrists checking whether they have understood the patient correctly,
whether they should understand how they experience their voices, how often and where they occur, provoked by which circumstances, or whether they have any meaningful content for the patient, etc. etc., this bread-and-butter aspect of the clinical encounter, where the psychiatrist tries to ‘get a fix’ on the nature of the phenomena in a shared perspective with the patient, involve facts, values, goals, and wishes. The ‘understanding’ the psychiatrists are pointing to, in my opinion, is the singular and situationally embedded co-occurrence of factual, evaluative, and pragmatic elements. Psychiatrists repeatedly remark they wish to be ‘faithful’ to the phenomena within the encounter. They do not say, for example, they wish to observe accurately, or judge correctly. This sense of ‘faith’ towards the phenomena I believe better captures the act of applying multiple frames of reference in describing what is experienced in the clinical encounter. Though perhaps closely related to pragmatism or pluralism, this is not equal to these positions since it is based on an interpretation of mental disorder as fundamentally heterogeneous, hybrid, and context-bound. Though this does not provide us with clear-cut criteria for what constitutes an ‘unfaithful’ description, it does provide some guidance, in prescribing certain relevant knowledge communities for certain clinical states. Moreover, the values-related elements also point to relevant moral communities, e.g. professional ethical frameworks, the ‘stakeholders’ mentioned in Fulford’s values-based practice, the democratic structures suggested by Sadler (2005). Such communities can also constrain what is understood by ‘mental disorder’, as one or more concepts thereof will be embedded in their practices and institutions (this approach will be taken up further in Chapter 9). The main difference between the practice espoused here and the dominant, dichotomized 'fact/value' model is the requirement of an analysis combining factual and evaluative frameworks at a deeper level than conventionally applied.

The punctuated description of combining this holistic apperception of the phenomena to the relevant epistemic frameworks and knowledge communities, to perceive and understand relevant and to integrate these with a view to diagnosis and treatment, could be termed ‘clinical judgment’. However, this is a sense of clinical judgment which includes a form of normative sensitivity which seems to go partially unrecognized by participants and of which they, on the whole, seem less secure than of their scientific credentials (though there is much variation): values to them are not only shakier ground than facts, their professional identity is more closely wedded to the latter. Part of the slightly mysterious concepts of ‘clinical expertise’ and medical phronesis may involve a normative skill which, so far, has to a degree gone unacknowledged. As a suggestion, the term ‘attunement’ might be apt, as it combines a sense of harmony and consistency and a sense of directedness and attention.
Chapter 8

The two senses in which the concept of disorder may function in practice, qualifying and constitutive, have been explored in this part of the study. The first sense, of demarcation, we found, is rarely questioned in the setting examined: there is no conflict of interests. In the following chapter, we will study the gatekeeping role of concepts of mental disorder from historical and social perspectives. The ways psychiatrists implicitly conceptualize disorder in the second sense, however, does tell us something about the connections between disorder and legitimacy. Disorders can be disordered in different ways, but not all disorders are equal. There is causal dualism and a tendency towards material realism in the psychiatrists: disorders are conceptualized in a continuum from ‘psychosocial’ to ‘biological’, and the latter are the more ‘real’ disorders. As we saw in Chapter 3, there is a tendency to align cause, ontology, disorder, treatment, and professional role together: the ‘really real’ psychiatric disorders are material-biological in nature, require pharmacological treatment, and are legitimately attended to by physicians. The ‘lighter’ side of psychiatry comprises the psychosocial disorders, seen as more mental in nature, requiring psychological treatment, suitably provided by psychologists. This general, abstract scheme is modulated, however, by the professional apperception of the phenomena at hand, in the form of ‘attunement’, set in a pragmatic perspective. From the perspective of the question of legitimacy, it is interesting to note the paradox: the psychiatrists feel more epistemically secure in a scientific, factual framework, but recognize the limited scope thereof in practice and value the pragmatic freedom this limitation affords: “Unfortunately but thankfully, we don’t know all that much about the brain.” Their professional expertise fills an important legitimacy gap in this sense, though there is more variation between participants in their confidence relating to value judgments, and whether this is a legitimate part of their expertise (in a way echoing Fulford’s point about value diversity in psychiatry). These variations also mirror the previous discussions relating to the presence of values in classification, and the possible role of pragmatism and values-based judgments in the development thereof. Questions asked there are repeated here, on a smaller, individual scale: pertaining to the DSM, we wonder whether it is wise and legitimate to alter diagnostic criteria in order to ward off ‘false epidemics’, here we wonder whether it is legitimate to perform an ‘ontological shift’ in (re)conceptualizing a patient’s mental disorder in order to reach a treatment goal. And equally, the question is not only on the form of legitimacy, but also, what is its scope: if psychiatry, or the individual psychiatrist, takes on a pragmatic, normative perspective, what should the appropriate scope be? What is best for the individual? For society? Whose values should be involved? For now, it is safe to conclude that this part of the study has confirmed the place of fact and value in the action of disorder in individual practice, and its heterogeneous nature. The implications for
individual practice will be addressed in Chapter 10. First we turn to the historical-societal perspective, which may offer more clarity on the general demarcation role of the concept of mental disorder, and how this concept is constituted by science, society and profession.
8.5. Main points Chapter 8

- The concept of mental disorder is central to debates in philosophy and psychiatry, being seen as highly socially and historically relevant. This debate is ongoing without a single proposal being dominant.
- Many of these proposals were identifiable in practice, with slight variations. Different MD concepts are applied by individual practitioners in a context-dependent manner.
- Participants applied plural disorder concepts both across and within different clinical situations. This accorded with their explanatory pluralism and pragmatism.
- Causal (ontological) dualism, explanatory pluralism and pragmatism combine to produce ontological heterogeneity with respect to mental disorder.
- As diagnosis is both identification and construction, in practice the ontology of the disorder is an emergent attribute, both cause and effect in the dynamics of the DEF.
- Ontologies of mental disorder from society, science, profession, and institute impinge on these dynamics as ‘scene-setting’ with variable potency, setting limits on pragmatism.
- The ontological scope of phenomena offers practitioners room for explanatory pluralism and pragmatism. This is an entry point for values.
- The relevance of MD concepts for practice lies either in boundary-setting conditions or in the abovementioned dynamic.
- In morally-laden boundary issues such as involuntary admission, there is a variation as to the confidence with which practitioners make values-related decisions.
- Philosophies of mind held by practitioners are mostly implicitly present, rarely being argued for.
- The findings suggest mental disorders can be validly disordered in fundamentally different ways relative to local contexts.