Chapter 9: Mental Disorder: historical studies and ontologies in action.

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9.1. Introduction
The aim of this chapter is twofold. First we will examine what role conceptualizations of mental disorder have historically played in demarcating and defining the domain of mental health care. The historical overview will be followed by philosophical work examining the products thereof and of the previous chapter. We will be aiming to answer the question: just what understanding of ‘mental disorder’ is most suitable for mental health care practice?

The initial focus is describing the nature of the concept of disorder ‘in action’ in societal settings, chiefly within the mental health practice domain. As we saw in the previous chapter, from practice we do not get a sense of a unitary definition shared by all practitioners defining their domain. The central role of contextual ‘clinical judgment’ affecting the demarcation problem raises the question what legitimacy the psychiatrist has in defining his or her domain based on an individually determined notion of the good. As mentioned previously, the question is whether a generally accepted definition of disorder could and should function as a boundary setting concept, to ward off arbitrary or idiosyncratic judgment on a matter of significance. To the narrow practice perspective of the previous chapter, historical analysis adds a broader sociocultural view. A selection of examples from three historical periods of interest has been made: the transition from pre-
Enlightenment to Enlightenment conceptions of insanity, the late 19th century and early 20th century, which saw an epidemic of neurasthenia and the gradual rise of psychoanalysis, and 2 demarcation controversies of the past decade pertaining to the DSPD (Dangerous and Severe Personality Disorder) concept in England, and to a recent government mental health report in the Netherlands. The methodological perspective taken is that of science studies, including applications of actor-network theory. For each example, first the historical background will be sketched, followed by a network analysis. After the examples, we will examine common features and trends observable in the analyses.

9.2. Historical studies

9.2.1. The early Enlightenment period

As was apparent from Chapter 5, the sociohistorical production of a domain of mental disorders within which psychiatrists attained a dominant professional position, was a sequential process rather than a co-occurrence: from classical times, physicians had already attended the insane, but shared the domain with religious healers, clergymen and custodians. In a fascinating historical study, Engelbrecht (2013) charts the gradual transition from religious, supernatural and preternatural understandings of insanity towards a psychological-medical understanding. The following account is mostly sourced from his work. The common perception of this development is that medieval religious and superstitious conceptualization gave way to empirical, scientific understanding, made possible through the Age of Reason and the Enlightenment. Engelbrecht's account shows this to be an oversimplified and reductive view. He begins his study in the 16th century at the height of the witch trials, focusing on the situation in England.

To gain a fuller understanding of this period, one must transport oneself into a pre-Cartesian understanding of mind and body, and the place of the soul therein. This implies a significant departure from current views. Engelbrecht refers to Febvre's concept of the outillage mental to refer to the assemblage of concepts, knowledge and basic world views that an individual receives from a given culture (or is born into) (Febvre 1947). The simple idea that we think with our brain was not the general opinion held at the time: what we now see as emotions and cognition were hypothesized to derive from heart, belly, brain or genitals. Also, atheism was not a cognitive option at this time. Faith, in whatever form, was a fundamental fact of life. 16th-Century man was embedded in a cosmic web of spirits, demons, and natural and supernatural powers. Thoughts were seen as part of an ether-like substance which was a conduit for forces human, sacred, and demonic. Our current
conception of an autonomous self too is part of a modern worldview at odds with a conceptualization of the mind and body of man as a battleground of determinative sacred and demonic forces. Around 1600 the human body was thought to be invested with a (Platonian) tripartite soul. Each part of the soul fulfilled specific functions and had specific qualities corresponding to specific forms of behavior, thoughts, and feelings. But the soul was also connected to cosmic and earthly elements: planets, stars, and metals. Human functioning was guided by three formative principles: the bodily, the soul and the sensitive. The bodily (or natural) principle resided in the liver, the base of sustenance, and in the genitalia, the base of procreation. The vital principle, delivering of life, was located in the heart, and the sensitive, or animal principle, in the head. The natural, vital and animal souls expressed their powers through the medium of spirits: tiny ethereal parts, whose form corresponded to their function. Vital spirits resembled flames, fitting with their life-giving force (and suiting the idea that a prime function of the heart was to warm the humors). Animal spirits resembled light, corresponding to their function in thought, which seemed to move at the speed of light. Natural spirits were produced in the liver, where food was transformed into blood. They flowed through the veins fulfilling basic physical functions such as growth, digestion, reproduction and restoration. Part of the natural spirits flowed to the heart, where they were invested with air and soul, transforming them into vital spirits, providing life force and inspiration (to be taken literally!), binding body and soul. Some of the vital spirits passed through the brain, where they were further refined, into animal spirits, the most ethereal of the three. These were capable of perception and imagination, and enabled movement, through passage through the nerves.

The understanding of insanity of the time was divided between natural and supernatural causes. Supernatural interpretations of insanity could be sacred or demonic, and such interpretations implied the attendance of members of the clergy. Natural causes were located within the body, and were the prime domain of physicians. The approach to these causes was firmly grounded in classical humoral theory, (relative) overabundance or lack of one or another humor seen as causing one of the then identified natural forms of insanity. Locating such causes within the body did not preclude any causal role for the mind and emotion however: black bile, cause and name of melancholia, needed to feed on fear to become overabundant, resulting in sadness, paranoia, and hallucinations. The same applied to the supernatural: it was the soul weakened by fear or guilt which allowed witches to affect the spirits, and for demons to possess them. This was made possible by the conviction that ghosts, demons, and the (bodily) spirits were all of the same, ethereal substance.
To read Engelbrecht’s descriptions of the medieval scheme of man is to be impressed by its openness: mankind as part of a Divine Order which was fundamentally connected. The open relationship between mind and body which to us seems so philosophically complex, was straightforwardly accepted within this framework. And though a transformation from this conceptualization to our current understanding seems to require a revolution, the reality Engelbrecht describes is far more of a gradual evolution, wherein societal change and scientific discovery were both influential and perhaps necessary requirements for change.

From the Reformation onwards, there was an increasing tendency in protestant and anti-Catholic circles to distance themselves from the more ritualistic and magical elements of religious theory and practice. Allocating such power as the witches supposedly wielded to Midworld entities was incongruous with the Divine nature thereof. The result was a gradual ‘centralization’ of the spiritual world (in God), and a literal de-enchantment of the natural world. This was not, however, an inevitable and linear historical progression, but an outcome of a prolonged struggle and interaction between scientific, secular, and religious world views, which at the time were inextricable from royal and political struggles (cf. Brooke 2014).

Engelbrecht offers a detailed description of the famous Mary Glover case (Almond 2004), which concerns the alleged demonic possession of a young London woman, and provides insight into the reasoning of two physicians battling over the diagnosis, one arguing for natural causes (Edward Jorden22) and the other for demonic possession (Stephen Bradwell23). The case, in which her neighbor Elizabeth Jackson was accused of witchcraft, became a local cause célèbre, and attracted the attention of, amongst others, bishop Richard Bancroft24. Bancroft saw the witch hunts and demonic exorcisms as examples of Catholic and Puritan ritual magic, and therefore a threat to the Christian (Anglican) Church. He had good reason for this, because these religious spectacles had succeeded in attracting and converting new followers (the Anglican Church at the time was the official national religion). So with regard to the battle between humors and witchcraft the stakes (no pun intended) were high.

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22 Edward Jorden (1569 - 1632) was the first English physician who viewed the women who were accused of witchcraft as unfortunate persons suffering from a medical condition.
23 Stephen Bradwell was admitted to the College of Physicians in 1594, despite lacking a medical degree. He was the son-in-law of the distinguished physician John Banister.
24 Richard Bancroft (1544 – 1610) was an English churchman, who became Archbishop of Canterbury and the "chief overseer" of the production of the King James Bible. At the time of the Mary Glover case, he was Bishop of London.
An interesting feature of the Glover case is that it illustrates how empirical exploration was not limited to Jorden, whom we would tend to view as more aligned with ‘natural science’. In fact, throughout the case it is Bradwell who exerts more effort in empirical work, offering detailed descriptions of signs fitting possession (being unable to eat in the presence of the alleged witch, episodes of hysteria, mysterious swelling of stomach, chest and throat), and performing verificatory experiments, even employing blinding methodology in order to prove demonic influence: the patient was blindfolded and exposed to either the alleged witch or a ‘control’, or the witch was disguised to simulate another housemaid, and the subjects’ reactions were noted and compared. Jorden had, through similar empirical methods and logical reasoning, attempted to explain the patient’s behavior by way of hysteria. In private, he suspected she was simply simulating this behavior after an argument with the housemaid. Such an explanation, however, was impossible to prove and would not have been acceptable in public opinion. The judge pushed him to show the courage of his convictions: if he truly thought the patient was hysterical, he should treat her, and the success of such treatment would convey further proof: “Give me a natural reason and a natural remedy, or a rush for your phisicke.” Jorden relented, probably considering that given the girl’s motivations, such a treatment would be unsuccessful. Jorden lost the argument, and Elizabeth Jackson was sentenced to the pillory and year-long imprisonment. Fortunately, according to Scull (2012), her influential supporters quickly secured her release.

Jorden’s time would later come however. King James VI of Scotland, who had ascended to the throne at the age of 16, also became king of England in 1603, following the death of Elizabeth (becoming James I of England in the process). Previously, he had been a driven supporter of the witch trials in Scotland, displaying a marked interest in the trials and experiments themselves. His regal ascendancy in England coincided with the puritan and Anglican conflicts, and both camps hastened to ally themselves with the new king. The aforementioned bishop Bancroft used Jorden’s (1603) publication on hysteria (criticizing witch trials and demonic rituals and supplanting supernatural explanations with the workings of the imagination) to try to convince the king, and succeeded, perhaps in part due to the king’s inquisitive mind. This led to prolonged cooperation between king, bishop and physician aimed at exposing false claims of supernatural activity. It goes without saying that the king’s support was a major boost for the skeptical position. Further support came from scientific developments, chiefly amongst which William Harvey’s (1628) discovery that the blood vascular system was actually a circulation. Previously, the vascular system was thought to function as a set of tunnels through which spirits and humors flowed in both directions. This was a
crucial empirical basis for humoral theory, allowing for ebbing and flowing through different regions of the body, and accumulations of one humor in one specific area or organ. Harvey however discovered that the valves in veins only permitted flow in one direction. To him, the implications of this discovery were immediately apparent, but it was not until after his death that his theory was accepted, in part due to defensive resistance from the main body of science, still firmly entrenched in humoral teaching, and in part again, due to political circumstance: religious and political conflict escalated into Civil War, which Cromwell’s Puritan army won. Harvey, an Anglican, was forced to flee and his laboratory was plundered. His circulatory theory only became accepted after the discovery of the microscope allowed Marcello Malpighi to demonstrate the distal connections between arteries and veins.

Engelbrecht’s view of scientific and metaphysical historical development shares some features with the kind of network analysis exemplified by actor network theory. Commenting on Foucault’s claim that the ‘open physical space’ of the body described above was suddenly closed, not after anatomical experiments (and therefore supposedly through general societal forces), Engelbrecht argues against such revolutionary views of conceptual and scientific change:

“Isn’t it rather the usual state of affairs that new ideas, especially if they contradict a huge framework of established thought, remain dormant for a long time, are reconsidered, attacked and defended, and only later, when surrounding concepts have also been questioned, are accepted? If we conceptualize our view of man as a network of concepts, then the likelihood of one disruptive concept damaging a whole network is small. We tend to forget that many elements of an established world view are embedded in thought, are experienced by people as real, and that their intuitions and perceptions have developed in interaction with such views. One will not immediately concede such views if a new theory pops up.” (Engelbrecht 2013 p.243, translation by the author)
In this network scheme, the supportive connections of the concepts of supernatural and natural insanity are drawn. Crucial developments influencing the network have been divided into red (antagonistic) and green (supportive) connections. The tightly knit metaphysical connections at the center served to retain stability of the concepts even in the face of Harvey’s discovery. However, once these connections were severed through historical political developments, illustrated by the transition from King James VI to King James I, the network was decisively weakened, and a mechanist, naturalist concept of insanity remained: insanity was disenchanted.

Engelbrecht’s historical account draws our attention to the fact that not only do phenomena attain meaning within conceptual systems (the *outillage mental*), but that such conceptual systems are, themselves, embedded in scientific and social
networks, whose connections historically intertwine. Moreover, an explanatory account of the development of science, as we can see from these examples, cannot proceed without taking the sociopolitical realms into account. King James I’s hand in supporting naturalistic explanations of insanity is an equally valid explanatory fact in the development of our current notion of mental disorder (in the sense of allowing for the conceptualizations that are available today), as Harvey’s discovery of the circulatory system. Now an argument could be made that such relationships have been driven back just by the Enlightenment and the co-development of science and technology. We will therefore examine more recent cases.

9.2.2. Neurasthenia and psychoanalysis

In the 17th and 18th centuries, with respect to the human body and mind, interventionist Divine Order gradually gave way to a more deist Cartesian dualism and humoral theory was replaced with a systematized, mechanistic picture of the workings of the body, the spirits and humors replaced by pulse, nervous energy, and magnetism. The brain was firmly established as the seat of the mind (or soul, whereby the centralization of theology was mirrored in anatomy), and anatomical, physiological and pathological knowledge of all organs expanded significantly, accompanied by growing influence of the Virchowian lesion model of disease in the second half of the 19th century. Though the mind had been separated almost entirely from the body by Descartes, this did not imply its autonomy. From the body, the mind could either be influenced by lesions in the brain, (which became the prime object of psychiatric investigation throughout the nineteenth century), or due to ‘false impressions’ leading to irrational beliefs. This latter theory was based on connectionism, which offered an explanation for external causes affecting the mind, and paved the way for legitimate interest in the mind, most apparent in France in the work of Pinel and Esquirol. The early 19th century was dominated by struggles between the Romantic Psychiker (France) and the Materialist Somatiker (Germany) (Weckowicz and Liebel-Weckowicz 1990). We saw previously (Chapter 7) that in Germany and the Netherlands, in the late 19th Century a decisive (for the attainment of academic recognition) move towards natural, physical science was made, but also, that at the end of the century, the lesion model had failed to fulfill its early promise. Academic recognition, scientific optimism and therapeutic pessimism co-existed at the fin de siècle. This ambivalence with regard to Modernity was reflected in the rise of an affliction emblematic of the period: neurasthenia. In the following review, the setting is American society of the late 19th Century. The place of neurasthenia in American culture, however, is not entirely representative of its place in other cultures (Gijswijt-Hofstra and Porter 2001). The scope of this study precludes a full treatment thereof.
The neurologist George Beard introduced the term neurasthenia, which indicated a ‘disease of the nervous system, without organic lesions, which may attack any or all parts of the nervous system, and was characterized by enfeeblement of the nerve force, which might have all the degrees of severity, from slight loosening of these forces down to profound and general prostration’ (Berrios & Porter 1995, p. 510). The clinical picture might consist of a variety of symptoms from diverse organ systems (cardiac, gastric, ocular etc.), but at the core lay ‘nervous exhaustion, characterized by undue fatigue on slightest exertion, both physical and mental’ (Cobb 1920). Neurasthenics had “abnormally quick fatigability and slow recuperation” (Jaspers 1959). As the definition attests to, an important feature of patients with neurasthenia was that they were not afflicted by organic lesions or identified somatic diseases. In other words, neurasthenia was a functional disease (in the late 19th century, theories following functional accounts of organ systems rather than lesion accounts thereof were increasingly influential). The definition also points to a variability in presentation, which indeed was the case: neurasthenia comprised chronic fatigue, depression and mild melancholia, or ‘depressed cortical activity’, and could afflict both women and men.

In keeping with the predominance of attention to clinical course at the time, neurasthenia was thought to be a forerunner of all mental illnesses, an intermediate affliction between mental health and full-blown insanity. Though early theories on the causes of neurasthenia focused on the reflex arc, these were quickly supplanted with the late 19th-century central paradigm of nervous disease, the nerve force, which was modeled on the discovery of the laws of thermodynamics and conservation of energy. The mind was seen as a set of psychological energies (an early precursor of Freud’s theories), and neurasthenia was seen as a pathology in relation to this system: ‘cortical weakness’ or ‘cortical irritability’. Depletion of cortical energy could derive from multiple sources: from within the body, through toxins or a failure of cerebral blood flow, or from increased demands from without: overwork, infection, or external toxins. Also, and crucial to its role in the social sphere, individual predisposition could affect one’s susceptibility to such influences, through exceptional sensitivity, a trait which was also seen as hereditary. In the theory of neurasthenia therefore, the main scientific views of mind and body of the time (functionalism, connectionism, nervous energy, heredity) converge.

Now that the term itself is no longer in medical use, it is hard to imagine the scale of neurasthenia at the time. It was of epidemic proportions: “By the end of the century, few families in the upper echelons of society in Europe and America had been unaffected by neurasthenia in at least one of its myriad forms.” (Lutz 1995). Another feature of neurasthenia was its demographic locus: where insanity mostly affected the poor and, in the parlance du jour, the degenerate, neurasthenia was an
affliction of the middle and upper classes, the ‘leisure classes, artists and brain workers’, most involved with ‘the modern’. Neurasthenia’s theoretical openness to environmental causes allowed it to be connected to the supposed effects of the Industrial Revolution and wider Modern developments. The sheer speed and burden of change, urbanization, transforming living circumstances, altered roles (including, perhaps most significantly, the burgeoning Woman’s movement), all amounted to the famous ‘pressures of Modern living’, where we should realize that the word ‘pressure’ should be taken in a far more literal sense than we understand it now.

However, falling ill under such pressure was not associated with the stigma afforded to the insane, but instead seen as a sign of exquisite sensibility, the hallmark of the artist, and a byproduct of the progress to new heights of civilization. Beard (1881) argued that five crucial features distinguished modern society from the ancient: ‘steam power, the periodical press, the telegraph, the sciences, and the mental activity of women’ and concluded that the epidemic of neurasthenia proved that America was the highest civilization that had ever existed. Neurasthenia was also connected to a sense of moral economy: industry and procreation were morally sanctioned forms of behavior, wise expenditures of nerve force and an investment bearing returns, whereas forms of morally unacceptable behavior such as gambling, illicit sexual behavior (including masturbation) or financial malpractice amounted to a waste of nervous energy, leading to cortical depletion. It is not difficult to see the parallels between the rising influence of economic capitalism and this nervous economy. An episode of neurasthenia therefore was also seen as an opportunity for a form of moral recalibration, time out from one’s busy Modern schedule, to rest and reassess one’s values, hence the popularity of Rest Cures and other forms of escape, still popular to this day.

The moral dimension connects the conceptualization of neurasthenia and its treatment to wider social issues of the day, including class and gender. Women were taken to possess, at birth and constitutionally, less nervous energy than men, and were considered more sensitive. Women, in other words, were seen as naturally frail. One social backdrop of the time was the emergence of the ‘New Woman’, the independent, feminist, educated career woman. Popularized by Henry James (cf. Niemtzow 1975), the image of the New Woman was of a person who exercised control over her life at personal, social and political levels. The suffragette movement was effective in gaining some democratic rights for women, and employment opportunities were growing, especially in the ‘pink collar’ (service) industry. Some neurologists argued however, that New Women were destroying their own health by aspiring to positions accompanied by, for women, overwhelming pressure. The diagnosis of neurasthenia provided legitimacy to a
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conservative, traditional definition of femininity characterized by dependency and passivity. For men, meanwhile, neurasthenia legitimized expansionism, not only in their social endeavors, legitimizing a pioneering frontier spirit to business, but actually in their bodies themselves: an ample waist was a sign of a successful businessman (Lutz 1995).

**Neurasthenia actor network**

The network scheme of neurasthenia demonstrates the co-operation of general and particular scientific developments (the steam engine metaphor, degeneration theory), interacting with social consequences of the Industrial Revolution (gender and class issues). Both the social developments (a new category of disorder connected to middle and upper class) and scientific thought (degeneration and prevention) worked in concert to stimulate the extension of physicians’ professional domain to neurasthenia. In contrast to the general, encompassing world views we encountered in the first example of the (super)natural insanity network, here specific causal theories are at work.
Chapter 9

9.2.3. Psychoanalysis

Regarding psychoanalysis, a significant conundrum follows: if, as we have argued, the societal legitimation of mental disorder concepts is to a significant degree co-constructed by scientific concepts and metaphysical assumptions, and if these were firmly grounded in materialism at the turn of the century, how is it possible that Freud’s psychological concepts of Id, Ego and Super-Ego come to be accepted, legitimate instances of mental disorder? We will focus on the early years when the theory and practice found a foothold, and limit ourselves to the broad social and scientific domain, ignoring the fascinating (inter)personal developments attached to psychoanalysis’ development, for which we refer the reader to the extensive literature elsewhere.

Decker (2008) provides an international perspective upon psychoanalysis’ differential reception in European countries, focusing on Austria, Switzerland, and Germany. Of the three countries, Switzerland was most receptive to Freud’s theories and practice. In his native Austria, the dominant medical notion of the time was ‘therapeutic nihilism’, based on faith in the capacity of nature to heal, and the idea that medical efforts could do more harm than good. Medical education at Vienna University, where Freud and his contemporaries were schooled exclusively in diagnosis, instilled this view. Dominance of pathological-anatomical views of disease ontology resulted in limiting medicine to surgery only for those diseases for which anatomical lesions were identified. For psychiatry, such evidence was lacking. Freud’s claims for nonphysical disease were inimical to this metaphysical framework. In Switzerland meanwhile, therapeutic nihilism was far less influential. Swiss culture historically had featured a long-standing commitment of local communities towards the care of the needs of their inhabitants, including the health needs. Psychiatric hospitals therefore, were dedicated to treatment. Also, unique to Switzerland within Europe at the time was the separation of psychiatry and neurology. This separation implied a less materialist psychiatry.

Eugene Bleuler, professor at the University of Zürich and director of the Burghölzli psychiatric asylum and clinic, was not convinced by degeneration theories of dementia praecox, deriving from his clinical experience the notion that people with dementia praecox did not inevitably decline, and sought for and applied remedies, including psychotherapies before discovering psychoanalysis. Welcoming Freud’s ideas, he played a crucial role in the institutionalization of psychoanalysis within the Burghölzli, and within Swiss academic psychiatry. Academic psychiatry in Germany, meanwhile, was an entirely different matter. After the prolonged conflicts between the Somatiker and the Psychiker, and the victory for the former, psychiatry was strongly linked to the organic, the psychoses, and custodial care. The emphasis on materialism in psychiatry corresponded to an emphasis on
realism and materialism in politics: Bismarck's success in unifying Germany through force and diplomacy was a victory over the parliamentary attempts of intellectuals in 1848 (Decker 2008, p.606). Cartesian mind-body dichotomy was strongly supported, and the body was, for psychiatry, the object to be studied, and functionalism was only allowed for in the form of supposed bodily forces (see above). Moreover, in German academic psychiatry, the psychophysical parallelism of the Somatiker had triumphed over the connectionism of the Psychiker. Freud’s initial attempt at framing psychoanalysis within the organic material scheme through the Project famously failed, after which he necessarily moved towards a psychological framework, insisting that future science should prove or disprove his theories. However, the scientific onus of the time, especially for a theory as unorthodox as Freud’s, lay on providing physical evidence of one’s theory.

Psychoanalysis, throughout its first decades, never gained scientific recognition in German academic circles. Its growing social legitimacy in Germany was derived from its popularity with the lay public (though Freud vehemently opposed any attempts at popularization of his works), and first impressions of its potential effectiveness in the First World War. The fact of shellshock, which so clearly demonstrated the debilitating effects of experience upon the mind (thereby supporting psychological explanations), coupled with reports of successful treatment based on analytic theoretical grounds, boosted the social reputation of psychoanalysis. This applied to a greater extent to the effect of the Second World War, especially with regard to psychoanalysis’ standing in the United States of America.

In the early decades of the Twentieth Century, America had already proven to be more receptive to psychoanalysis. At the time America became acquainted with psychoanalysis, Peirce and James’ pragmatism was highly influential (Bacon 2012), with less emphasis on materialist-idealist debates, and a preference for more instrumental approaches. The initial contact with Freud’s theories was made during the late 19th century ‘Age of Reform’, when the country as a whole was highly receptive to ideas from abroad in the arts and sciences (Gifford 2008). There existed none of the nationalist flavor of the struggles between German Somatiker and French Romantics. William James, the eminent psychologist, welcomed Freud’s ideas and their optimistic therapeutic promise, which was in sharp contrast to hereditary degeneration theory. Psychoanalysis offered a practical solution, and was seen as more congenial to the ‘optimistic American temperament’. The contrasts between fin de siècle pessimism of Vienna and American optimism are marked. The growth of psychoanalysis in prewar America is a reflection of the pioneering, claim-staking spirit of the American Settlers themselves: a gradual buildup, grown around influential personalities and footholds in major cities (Boston, New York, Washington). Psychoanalysis in
America enjoyed greater communication with other academic disciplines, most notable psychology, than in Europe. The Second World War proved decisive in sealing psychoanalysis reputation as an effective treatment (see Chapter 4), and the immigration of eminent analysts dating from the Thirties, coupled with the influx of a substantial number of analytically-trained psychiatrists from the war effort formed the basis for its postwar domination of American psychiatry. The growing internationalization of academic psychiatry and growing mobility of individuals helped this influence spread to Europe, though psychoanalysis’ academic position remained variable between countries. In Britain, for example, psychoanalysis never gained a dominant academic position.
Psychoanalysis early 20\textsuperscript{th} Century actor network

This (simplified) network of the psychoanalytical movements adds to the previous descriptions of demonic possession and neurasthenia by illuminating the differential influence of \textit{locality} on scientific acceptance. Again, what was deemed scientifically acceptable was tied to the scientific and philosophical developments in the respective countries described, which, in their turn, were related to general social and historical processes. The history of psychoanalysis is also a demonstration of the value of distinguishing societal legitimacy from scientific validity. Throughout the history of psychoanalysis, the two were not always aligned. Therapeutic effect goes some way, it shows, in obviating (full) scientific validity if the results are promising enough and valued in society. The postwar development of psychoanalysis reflects an impressive faith in the potential fruits of psychoanalysis in medicine and without, in areas such as education, public health, and commercial development. As the historical review of developments surrounding the ‘DSM-revolution’ of the Seventies showed in Chapter 4, it was in a
period in history where the interests and values of psychoanalysis and American society (by way of the American Government) diverged, that a new taxonomic framework was installed inimical to psychoanalytical theory.

9.2.4. Dangerous and Severe Personality Disorder (DSPD)
We move now to the recent present. We will examine two cases, revisiting DSPD and examining arguments involved in a recent Dutch controversy over reimbursement, centering on a report by the Dutch health institution the ‘College for Health Insurance’ (College voor Zorgverzekeringen, CVZ) charged with the responsibility of defining and demarcating the 'basic package' of insured diseases and disorders within the national Insurance framework.

DSPD actor network

The analysis of DSPD in Chapter 7 was focused on the social and political networks surrounding DSPD (Manning 2002), and less on professional psychiatric concepts. The ANT analysis can be extended, or perhaps shifted, to analyze the network
surrounding the ‘concept of disorder’. What concepts are invoked that afford DSPD illness status?

For current purposes, we do not need to fully examine the connections and content of the network, since the main aim of presenting this part of the network is to illustrate a few interesting differences with the previous networks. (To this end the actors with strong network positions (nodes) have been accentuated.)

Firstly, the network illustrates the institutional growth and differentiation of all societal groups in comparison to previous examples. Institutions can be erected by government and populated with professionals on the basis of shared interests and views. ‘Society’ is represented in varied ways. Secondly, nowhere in the network is a proven or a hypothetical biological explanation for DSPD relevant. Disputes on the scientific and legal legitimacy between professional opponents and supporters of the DSPD concept focused on the diagnostic reliability thereof, its statistical construct validity, and its treatability. It is the prefixes ‘dangerous’ and ‘severe’ which are contested by network actors, not the category of personality disorder. (And certainly not the general category of mental disorder.) This whilst the legitimacy of personality disorder from the viewpoint of a biological perspective of disorder is highly contested elsewhere, including, in fact especially, forensic psychiatric contexts. It was open to the professionals to contest the biological foundation of personality disorder itself, but they refrained from doing so, even though a valid attempt at doing so could have been framed as a comparison between axis I and axis II disorders. Of course, as the network shows, there would have been a price, namely in severing connections to the personality disorder network (shown partially here). It is tempting to conclude that for the participants in this network, there was no conflict surrounding personality disorder. This depends on who is admitted to the network. For those persons diagnosed with a personality disorder, their attitude to such a diagnosis varies, especially within forensic settings. Though not studied, we would expect at least part of the network of human actors receiving the DSPD diagnosis to contest the PD category itself. However, such actors carried little agency within the network: they fulfilled an important role as a societal category, not as individuals with agency.

One feature of this network analysis is that it shows that psychiatry as a profession does not always attempt to legitimize (or in this case, de-legitimize) mental disorder in relation to a biological-material form of validity. The prime materials sustaining DSPD were the bricks and mortar of the DSPD units and 126 million pound coins. There were clear political motives behind the construction of the category. This example demonstrates what some might see as the attempted infiltration of a sociopolitical category into the scientific domain. However, as was
apparent, professional groups did not align as one against unwarranted intrusion: their responses too were driven by professional, scientific, and pragmatic interests. All examples so far show how definitions of mental disorder in action in science and society function in relation to a local context which is co-determined by scientific and social communities.

In the case of DSPD, its success hinged on its cost-effectiveness, since from the outset it was part of a Government project to allay public fears in a concrete fashion. Some years later, it became apparent that in at least one unit (Broadmoor Hospital) the treatment approach was insufficiently effective to justify the expenditure, and the unit was closed (Leake 2010). Henderson Hospital in Surrey closed in 2008. Cassel Hospital still offers help for personality disorders, including ‘severe and complex’ personality disorders, but there is no identified DSPD unit. An internet search for VISPED yielded no current results. A new strategy was developed by the Department of Health and Ministry of Justice under the ‘Offender Personality Disorder Pathway Implementation Plan’ (UK Dept. of Health 2011). On the government website, no mention is currently made of the concept of DSPD. In retrospect, the crucial actor in its network was ‘cost-effectiveness’, and once the connections to this actor were lost, the concept itself was left unsupported and gradually disappeared.

9.2.5. The CVZ report

In 2012, a controversy erupted in the Netherlands after the publication of a provisional report by the CVZ (CVZ 2012), the institution then responsible for determining which health problems should be included in the ‘basic package’ of health insurance within the so-called Health Insurance Law (ZorgVerzekeringsWet, ZVW). Admission into the basic package guaranteed insurance coverage for all citizens with such disorders. The minister of Health had asked the CVZ to redefine the boundaries of the mental health care package allowing for only ‘uncontested diagnoses’ (to paraphrase a much-admired fictional character, obviously the minister is not a philosopher) (ibid.). The CVZ produced two reports, both highly contested (CVZ 2012, 2013). These reports are instances of boundary conflicts over the domain of mental health in which all major stakeholders were involved. Therefore, they are valuable material for studying the possible action of concepts

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25 http://ezitis.myzen.co.uk/henderson.html
26 http://www.wlmht.nhs.uk/cs/cassel-hospital-services/personality-disorder-service/
27 “Obviously you’re not a golfer.” From ‘The Big Lebowski’, written & directed by the Coen Brothers. Readers unenlightened by the wisdom of The Dude are referred to the many websites devoted to his contemporary mix of taoism and loose-fitting wardrobe, e.g. the ‘Church of the Latter-Day Dude’. http://dudeism.com/
of disorder in such a dispute.

In the introduction to the first report, the CVZ set out the political and economic background of the report: in view of the recent financial crisis cost containment issues were at the forefront of all public service debates, including mental health care. The CVZ, based on data from the Health Insurance companies, calculated there had been a substantial increase in spending within mental health care in the previous decade (€3.5 billion in absolute terms from 2000 until 2010, an increase of 146%. The increase of the total health budget in the same period was 114%, according to the CVZ). Government focused on the legitimacy of those receiving care. A further report (KPMG 2012) stated that health insurers, tasked with requisitioning health care, were insufficiently equipped to check whether care was being provided by suitable licensed practitioners and to what degree lesser-qualified (and cheaper) practitioners were being assigned to treat conditions for which reimbursement level had been determined relative to treatment by practitioners with higher level qualifications (a profit for the health care provider at the expense of the insurer).

Dutch mental health care at the time was going through a process of gradual liberalization, resulting in a transfer of responsibility for quality control from government institutions to health insurers. From these perspectives the preference of third-party payers for reliable operationalizations of criteria for reimbursement is understandable.

Space limitations preclude a full analysis of these reports, instead, for this chapter, arguments over the report will be presented featuring concepts of (mental) disorder. In the first report, the CVZ framed the demarcation in terms of ‘complaints’ versus ‘disorders’. This in itself does not provide much conceptual guidance, since disorders inherently consist of complaints, a point made by many stakeholders. But a further concept was added: “Mental complaints are not necessarily by definition diseases.” (CVZ 2012 p. 19.) The report did not define the latter, and chose a case-by-case approach, together with reference to two general guidelines derived from the Health Insurance Law, namely that medical care is that which “general practitioners, clinical psychologists, medical specialists and midwives are accustomed to give,” (The CVZ omitted the Dutch “mede” which means “amongst others”) and that care should be based on the current state of science and practice. In a previous report the latter had been equated with evidence-based medicine (CVZ 2007). The following conditions were deemed not to qualify for the category of disease, for diverse reasons:
- DSM V-codes, since they were not ‘axis I disorders’, were not seen as disorders, and therefore, not as diseases. Being an axis 1 disorder was a necessary but not a sufficient condition).
- Psychosocial care: supportive treatments of a practical and social nature are provided by Social Work.
- Learning disabilities, including dyslexia. These are "not mental conditions, but neurophysiological ones."
- Dementia cannot be precisely demarcated: the National Guidelines for the diagnosis and treatment of dementia were drawn up under the purview of the Dutch Clinical Geriatrics Society, and there are a number of multidisciplinary ‘memory policlinics’ in general hospitals. This implies the demarcation involved is between mental health care and general medicine.
- The CVZ noted that the minister had previously decided to remove Adjustment Disorders from the BP on the grounds that the disorder is generally associated with a low illness burden.

In the following, a selection is made of reactions from stakeholders from diverse backgrounds related to the demarcation via a general concept of disorder or via specific disorders. I have used italics to emphasize the kinds of arguments offered, an overview of which will follow below.

National Society of First-Line Psychologists (Landelijke Vereniging Eerstelijnspsychologen, LVE):

- Making treatment dependent on diagnosis leads to medicalization.
- The status of disorder does not necessarily imply higher illness burden and vice versa. Exclusion based on the requirement of diagnosis may result in unnecessary suffering, higher levels of illness absenteeism, and development of more serious mental health problems.
- Quality of care should be defined as ‘contributing to health and participation’, according to a report by the Public Health Care Council (RvZ). Singular focus on diagnosis is too narrow.
- Setting a time limit on empirically proven treatment prioritizes savings over health care.

Mental Health Care Netherlands (GGZ Nederland, GGZNL; representative body of a significant number of large mental health institutions, providers of both residential and ambulatory care):
- The exclusion of certain disorders has been done on an arbitrary basis and will lead to unwanted effects in the health care chain and to unjustifiable societal effects. Adjustment disorder, for example, is often a serious disorder which can lead to a more severe mental disorder, if it is not treated adequately and in time.
- MHCN prefers an illness-burden approach.
- Psychosocial problems are a known cause (e.g. domestic abuse) of illness burden in others, which should be taken into account.
- A case-by-case assessment of the V-codes is advised: these contain, amongst others, relational and systemic problems, which may be the root cause of the mental disorder.

The Dutch Society of Self-Employed Psychologists and Psychotherapists (Nederlandse Vereniging voor Vrijgevestigde Psychologen en Psychotherapeuten, NVVPP):
- A number of proposals will have disastrous consequences for clients, such as the exclusion of V-code diagnoses.
- Mental complaints can be associated with significant distress. There is a worrying tendency not to take mental complaints seriously because they're 'not real diseases'.
- 'Shopping in the DSM' for legitimate and illegitimate diagnoses fails to recognize the scientific status of the DSM.
- Excluding diagnoses will lead to replacement diagnoses being made. The effect on savings will be minimal.

The Dutch Society of Psychiatrists (Nederlandse Vereniging voor Psychiatrie, NVvP):
- The choice to allocate a certain form of care within the collective BP is a fundamentally political one, related to the degree and scope of solidarity on our society.
- Criticism is therefore only given where we feel quality of and access to care for people suffering from mental illness are at risk.
- Health Care has been dominated by an inadequate financial structure, therefore we support changes. However, correct allocation of care should be based on substantive grounds and performed by professionals, not by bureaucratic methods.
- The distinction between complaints and disorders is untenable.
- Though the DSM can offer a rough overview of the domain of mental disorders, it is not an instrument aimed at indicating burden of illness or assessing adequate care requirements. An added assessment is required, which necessitates clinical judgment, just as in the rest of medicine. We advise to stay away from micromanagement and control by health care insurers extending into the treatment office. This is the area where we should be afforded freedom as clinicians to work it out with the patient.
- Does the CVZ imply excluding just relationship problems or also those conditions due to such conditions? If so, then there is no parity with somatic care where many conditions may be caused by relationship problems.
- With respect to dementia, the location where treatment currently is given should not determine future allocation, but the nature of the affliction itself.

The National Platform for Mental Health Care (Landelijk Platform GGz, the national representative body for mental health care clients, LPGGz):
- Suggestions for curtailing costs should be made on the basis of a more thorough analysis of projected costs in specific areas, in view of the fact that many factors have been identified contributing to increased mental health care spending.
- The choices for specific exclusions are arbitrary, and the DSM is thereby used for a purpose it wasn't designed for.
- V-codes do not imply low illness burden.
- The Health Insurance Law is explicitly also aimed at prevention, for which there is little to no room in the report’s suggestions.
- The demarcation has unwanted side-effects.

Dutch Health Insurers (Zorgverzekeraars Nederland, ZN, the national representative body of the health insurance companies)
- The most fundamental problems for health insurers in carrying out their task are the demarcation problem with regard to insurance claims and the fact that insurers do not receive information regarding the relationship between ‘care demand severity' and the deployment of specific health care professions.
- DHI supports the argument not to take DSM-diagnosis as a sufficient criterion for demarcation but in its place no clear criterion is offered. This should be developed further whereby factors should be viewed as mental versus psychosocial problems versus mental handicap (sic) versus mental
disease, medical treatment versus nonmedical treatment, primarily mental versus primarily somatic.

- A possible structure could consist of a) Psychiatric illness for which treatment is primarily medical and directed at recovery from or improvement of the disease; b) Psychiatric illness where there is a chronic course and care is not primarily aimed at medical recovery but at recovery or improvement of self-sufficiency or improvement of social participation; c) Disorders of the DSM-IV that are not viewed as illnesses but as mental handicaps (such as autistic disorders and PDD-NOS) wherein treatment, after diagnosis, is nonmedical but directed at self-sufficiency and participation; d) primarily somatic care for which incidental psychological supportive treatment may be necessary and e) psychosocial support, learning disorders and pedagogical problems, which are not seen as mental disorders.

**CVZ Report Actor Network**

For clarity, the connections drawn in the network have been limited to supportive connections. A first glance immediately offers a striking divide, between network
connections surrounding precision on the left side of the diagram, and connections surrounding normative concepts on the right. The connections with the concept of illness burden have been emphasized, since it seems to be a concept forming a bridge between the stakeholders. Mental disorder as a concept functions as a demarcation for the precision-oriented cluster, and to this end the DSM is applied, together with attempts to refer to essences/causes. These are dismissed by the right-side cluster as arbitrary.

From a sociological perspective, the framing of the argument by a socially powerful group (the government) is relevant. The process has been framed politically, based on overriding goals of cost containment, and instrumentalism is entailed within the general framework of the argument. In this case, technical rationality and demarcation through codification are shared by the government, the CVZ, the MoH and ZN. These approaches entail specific epistemic values, central to which is precision. Due to the social power of the government, participants must engage with these central values and the implied epistemology in order to maintain relevance to the discussion and to retain, politically, a seat at the table. In this manner, the government sets limits on the scope of the argument. ‘Illness burden’ attains a central position, but is epistemically contested: can it be operationalized and codified, or should it be judged by a professional? From the perspective of this study the arguments of psychiatrists are especially interesting. They emphasize the autonomy of the professional and warn against bureaucratic encroachment thereupon. This fits with the worries over technical rationality mentioned in Chapter 7 and the historical development of increasing rationalization and bureaucratization of recent decades. The struggle over the epistemic perspective is equally a struggle about professional domain and autonomy.

The network analyses presented here are easy to criticize, since no account has been given of the reasons for selecting certain actors and omitting others. However, the aim here was not to offer a full sociological account, but to illustrate a number of specific processes that are operative in domain issues relating to the concept of mental disorder. Fuller accounts would be most welcome. A full exposition of such socially complex processes goes beyond the scope of this study, and that, in part, is the point: the examples illustrate the degree to which mental health has become more differentiated and institutionalized, with multiple representative groups, multiple governmental and semi-public institutions participating in the debate. For those anxious to know how this latter example turned out: the government did push through with diagnosis-related limitations, but at the same time a major reorganization of the mental health sector as a whole was enacted, setting entirely new boundaries and cut-off points between different
care echelons, in an attempt to reallocate resources more towards primary and ambulatory care services, in the hope of cost-containing effects of primary and secondary prevention. The conceptual debate as a consequence became somewhat marginalized... for now. This final example demonstrates how powerful societal groups can set limits on the conceptual range of debate on the demarcation problem (i.e. delimiting the outillage mental): whilst professional groups were mostly intent on entering into an ethical debate, the third-party payers, supported by the government, were more interested in attaining precision. This led to a preference for sharp ontological (somatic cause versus mental) or epistemic (V-codes, certain DSM diagnoses) boundaries.

Secondly, from this analysis, one gets the impression that there is no single ‘concept of disorder’ serving an influential role as an independent actor in the network. Rather, different concepts are put to instrumental use, depending on interests, and different arguments were used for different disorders. The concept of disorder is relevant, but more for tracking the outcome of the decisions, than as a cause thereof. The debate was dominated by instrumental reasoning on both sides of the argument. Psychiatrists were in fact the only professional group to refer to the nature of disorder in arguing for retaining a diagnosis (dementia) within the psychiatric domain.

In summary, the historical overview and network analysis have shown that conceptualizing mental disorder as a product of either society, the profession, or science, does not fit well with historical developments. A better perspective can be gained from seeing concepts of disorder emerging within communities with shared views and interests, interacting dynamically through time and space, co-creating mental disorder conceptualizations. These are molded both by the facts of the world, but also by metaphysical views, and social forces. Some concepts are more durable than others, but as they survive they may be translated and transformed. It does not seem that a unified mental disorder concept acts powerfully in this ongoing dynamic, rather, specific accounts tied to specific disorders or phenomena are deployed, but these are also context-dependent: where in one debate, a biological disorders concept strengthens a claim to be included into the psychiatric domain, in another, it weakens it. Professions do not always act as homogenous groups. Evidently, societal values, in many diverse forms, shape these processes. Shared values, as we have seen previously, can become inconspicuous, as in the shared instrumentalism of the CVZ example. Also, the sheer increase in size, scope, differentiation and institutionalization of the mental health field is a challenge for such analyses and debates. Finding a common ‘mental disorder’ concept for a diversity of phenomena and interests, even for a small country like the
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Netherlands, becomes an insurmountable task. This again indicates a need for lower-level, local, and contextual analysis.

9.3. Discussion
The historical examples demonstrate that interactions between science and society also take place at conceptual levels: society may define what is ‘thinkable’ through general, unassailable (blackboxed) and taken-for-granted views (e.g. demonic possession), a mental disorder concept may serve as a bridge (significant actor) supporting the aims of both profession and certain social groups (e.g. neurasthenia), and a mental disorder concept may also be initiated outside of the profession by social groups (DSPD), requiring specific efforts to gain a foothold within the profession. Scientific validity carries much authority in such interactions, but it is not the only factor. The examples of psychoanalysis and DSPD demonstrated that scientific recognition is not a *sine qua non* for societal legitimacy, though for a concept or theory to gain a place within the professional domain of mental health, supporting connections with professional actors are required. With respect to the discussion on mental disorder it is therefore necessary to distinguish between scientific validity and societal acceptance, whilst maintaining a fix on the idea that the two realms are not disconnected, but interact constantly and through different media. In societal action, different conceptualizations of mental disorder are deployed. These can be science-based, with network connections to concepts which have attained such degrees of stability that they have become ‘blackboxed’, in other words, attained the status of scientific fact, but equally metaphysical views or social aims can attain such positions (e.g. the Medieval Divine Order) or attempts can be made to do so (the DSPD network). In the final example, we see that in a boundary conflict, different conceptualizations of mental disorder are applied to argue for and against inclusion in the ‘mental health’ domain for different mental disorders.

What does this examination of ‘mental disorder in action’ imply for the issue of the concept of mental disorder? An initial conclusion is a linguistic admonition, relating to the first case: the importance of generalized but contemporary metaphysical views (such as those present in the late Medieval times) renders any likeness argument grounding current categories or concepts of ‘mental disorder’ on previous historical concepts, if not entirely incommensurable, highly precarious. As Berrios (2012) puts it succinctly:

“According to a conceptual narrative account, mental symptoms or disorders result from the “convergence” (in the work of an author or authors) of words, concepts and
associated behaviors which, on further analysis, are often enough found to have participated in earlier convergences. Given that there is no way of telling whether a later one is “truer” or “more valid” than a preceding one, convergences cannot be aligned on a “progressive” series. All that can be meaningfully stated is that each convergence constitutes a self-contained narrative expressing the best that a given historical period can offer. Mental symptoms and disorders are semantically configured cultural objects at the heart of which there is always a neurobiological signal. It follows that they are neither “pure” biology nor “pure” semantics and the challenge to psychiatric modelers is to respect their hybrid nature. This also means that in addition to biological data information is required on the purpose, assumptions and social frames of any classification, on what Lanteri-Laura (1984) felicitously called “les références non-cliniques.” (Berrios, 2012)

Attempting to prove the reality of mental illness categories by historically tracing symptomatology and ascribing to them current diagnostic labels is a profoundly ahistorical endeavor, and literally meaningless with regard to validation of current categories and conceptualization. The interaction of wider sociopolitical and religious developments with the metaphysical positions available to science on the one hand, and the actual discoveries themselves, illustrates the influence of societal values within (the development of ) scientific concepts. The network analysis offers the additional advantage of bringing into view specific interactions between social, scientific and professional groups, belief systems, and values.

The conclusion from the above is that we cannot see ‘mental disorder’ as a concept arising from either the societal or the scientific and professional spheres, rather as a consequence and a cause in local domain-setting negotiations. The pluralist and pragmatic use of mental disorder in these discussions mirrors the approach of the practitioners in our study. Mental disorders can be validly disordered in different ways relative to local sociohistorical/scientific contexts.

This may be the case historically and empirically, but should it be so? I would argue that judging ‘mental disorder’ should indeed be done from a local, and contextual perspective. The argument for this is in part philosophical and in part ethical. The first part of the argument follows in part from the historical overview, which strongly suggests that from a descriptive point of view, ‘mental disorder’ throughout history has been a practical kind. In reviewing the philosophical debate on the ‘kinds of kinds’ in relation to mental disorder, I will conclude that this is a minimal consensus position, and that, where there is a natural kind concept in place, this still requires a local, contextual perspective. Secondly, from the ethical point of view, I will argue that there is a consensus on the evaluative element within ‘mental disorder’. For practice (and there is also a pragmatic argument), this
implies a judgment of the values involved set against the relevant value context. The ‘first point of call’ of the latter should be the patient.

9.3.1. Mental disorders and kinds of kinds.
A central question in the debate on mental disorder has been whether mental disorders are natural kinds. Scientific disciplines divide the particulars they study into kinds and theorize about those kinds. To say that a kind is natural is to say that it corresponds to a grouping or ordering that does not depend on humans. The paradigmatic example of a natural kind classification is the periodic system of elements, which reflects natural distinctions between the phenomena. Conversely, ‘toys, ‘classical music’ and ‘British humor’, though they are not arbitrary collections, reflect our interests and are therefore not natural. Viewing the entities within the category ‘mental disorder’ as natural kinds is an important element in the scientific realist approach to disorder and taxonomy discussed in Chapter 4. One way in which a natural kind view can be grounded is, analogous to the periodical system, with reference to a causal or constitutional essence. In medicine, the lesion model provides a causal essence, an anatomical or physiological pathology, or an external pathogen. The ideal for this view of psychiatric disorder is to identify a specific etiological factor (often presumed to be biological). This factor then serves to bound the category objectively and sharply. Such an ideal is embodied by Robins and Guze’s (1970) framework for psychiatric taxonomy, and therefore it still informs the DSM-5. Boorse’s and Wakefield’s models of disorder also allow for a natural kind view.

The historical review seems to point away from natural kinds with respect to mental disorders, in view of the profound degree of interaction with and influence of social influences, interests, and pragmatism in their conceptualizations. Again though, we must be wary of committing the naturalistic fallacy. Naturalism need not maintain that current categories or classifications we take to be natural are in fact natural: we may be mistaken, and such practices as described above will be amended once the (essential) nature of disorder becomes apparent. This is in fact what Wakefield practices in applying his harmful dysfunction concept, seen as embodying the natural kind of disorder rather than our currently enacted concept, and subsequently proposing modifications to current boundaries, specifically excluding forms of sadness relating to loss (deemed to be based on evolutionary functions acting as designed) (cf. Wakefield 2013, Horwitz & Wakefield 2007).

However, taking a singular, essentialist natural kind approach to the general concept of mental disorder is widely rejected. There is a wider consensus that
although natural kind concepts may apply to chemical elements and compounds, the natural kind view does not translate into the biological domain (e.g. Dupré 1995). Cooper (2004) argues that essentialism regarding shared natural pathophysiological causes of mental disorder is an assumption which may be true for some disorders, but does not apply to all. Many disorders are such that cases of the same diagnosis do not share any fundamental property amenable to natural scientific study. Broome (2006) notes that determining what is a fundamental property is relative to a scientist’s theory, therefore this naturalism also commits us to scientific realism and to ‘converging evidence’ rather than epistemic pluralism if we are to retain hope of identifying nature’s pattern. Zachar (2000b) contrasts natural kinds with practical kinds. These are predicated on the idea that there are no clear boundaries present in nature which guide our hand in drawing distinctions between disorder and non-disorder, or between disorders. Nevertheless, in the field of mental health binary distinctions must be made, and these are made on practical, pragmatic grounds, which may vary and be contestable, but nevertheless are non-arbitrary since they are related to circumscribed goals, for instance in the case of mental disorder, the optimal identification of individuals who require treatment (note that this chimes with Sadler’s criticism of values subjectivism). Haslam (2002) argues against the identification of ‘mental disorder’ with just one kind: psychiatric diagnoses differ with respect to the categories that best capture them. It is mistaken to prioritize and generalize one model beyond its sphere of application. He adds a number of intermediate categories between the concept of “non-kinds” i.e. continua, dimensions along which individuals differ by degree alone, and natural kinds, where there is an identifiable causally efficacious essence (e.g. a gene invariably and exclusively associated with a constellation of psychiatric symptoms). Based on the variables of objective discontinuity, sharp and binary discontinuity, and causal essence, Haslam (2002) constructed a taxonomy of kinds for psychiatric disorders, including non-kinds, practical kinds, fuzzy kinds, discrete kinds and natural kinds (see table 9.1).
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<table>
<thead>
<tr>
<th>Non-Arbitrary Distinction</th>
<th>Objective Distinction</th>
<th>Sharp Discontinuity</th>
<th>Causal Essence</th>
<th>Example</th>
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<td>Neurosis</td>
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<td>Practical Kinds</td>
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<td>Depression</td>
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<td>Fuzzy Kinds</td>
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<td>Borderline Personality</td>
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<td>Discrete Kinds</td>
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<td>Natural Kinds</td>
<td>+</td>
<td>+</td>
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<td>Williams Syndrome</td>
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Table 9.1 Haslam's kinds of kinds (2002)

Haslam remarks that it is difficult to find examples of uncontested natural kinds in psychiatry. Fulford et al. (2006) added that when such kinds are identified, they historically tend to get 'kicked upstairs' to neurology (such reasoning was apparent in the CVZ motivation for excluding learning disabilities from psychiatry). An interesting result, therefore, of any project to 'naturalize' psychiatry could be its re-allocation to general medicine. In fact, this is one form of reasoning sometimes involved in claiming parity with general medicine: “Psychiatric disease is no different from disease generally.” The flip side of this argument however may have seriously adverse consequences. Haslam draws the general boundary between mental disorder and non-disorder between non-kinds and practical kinds, arguing, in agreement with other authors, that given the fact that medicine is fundamentally a pragmatic, modificatory activity, the fundamental line between disorder and non-disorder in relation to this activity is pragmatic, and related to aforementioned criterion of including those conditions that warrant treatment. On the 'uncontested natural kind’ criterion however, only those conditions with proven essential causation would qualify for treatment and, exactly on the lines of Szasz, mental disorder, as it currently stands, would become a myth. Of course, as Szasz argued, this would not entail abandonment of those in need of help, rather an altered understanding of their plight. However, I believe this conceptualization would lead to just that, and furthermore would lead to marginalization of the meaningful content of those disorders supposedly materially demarcated, based on the processes of alignment and causal dualism described in our study. For current purposes, we need not explore the further implications of Haslam’s taxonomy, only taking up the point of agreement with most other authors, that as a whole, mental disorders cannot be taken to be natural kinds, and that it is probable that they consist of different ‘kinds of kinds’, including practical kinds.
Applying this position to the CVZ example, the dominance of pragmatic arguments amongst the stakeholders is understandable as a manifestation of non-arbitrary practical kinds: boundaries may be contested, but this does not imply that reasonable arguments cannot be made. It also helps identify flawed arguments (such as identifying learning disabilities as a neurophysiological condition). Interestingly, apart from the CVZ, none of the stakeholders refer to an essentialist notion of disorder as a foundational claim, rather, general notions of suffering, illness burden and the pragmatic implications of choices are most frequently mentioned. Finally, it demonstrates a wider conceptual conflict: the minister of Health literally requested a limitation of the mental health domain to that which is 'uncontestably so'. The philosophical analysis shows that in doing so, she was making an unreasonable demand, as things currently stand: boundaries may be non-arbitrary, but this does not render them uncontestable (cf. Brülde and Radovic 2006).

Concepts of mental disorder may rest on societal interests, cultural assumptions, vary through time and space, and interact with both scientific discovery and public desires, but this does not make them arbitrary. Depending on their nature and their ‘kind’, different sorts of arguments are to be made to determine allocation, but these have validity relative to their domain and communities. The key issue involved is the appropriateness of the kind assessment. Haslam argues that this assessment is, at least in part, an empirical one. I would add, in agreement with Thornton, that the assessment of irreducible value elements in disorder and their allocation to a practical kind, is also connected to a form of judgment that is objective. Judging the appropriateness of a certain kind allocation is not an arbitrary matter. I would also add Haslam’s argument against generalizing kind ascriptions from one group of mental disorders to the general category of mental disorder. Reasoning alone does not a priori determine the level at which groupings can be made: empirical work is required. Such studies can be performed on any phenomenon or group of phenomena within psychiatry. Recall, for example, the impact that studies of the prevalence of hearing voices in the general population had on the conceptualization of hallucinations (Escher & Romme 2012). There is, therefore, much to be gained from empirical research, especially if it is combined with analysis of evaluative elements (cf. Widdershoven, McMillan & Hope 2008, Collins 1985).

This extension from deliberating on the general concept of disorder to that of individual diagnoses and to the ontologies of phenomena, when transported to the clinical encounter examined in chapter 8, accords with the findings thereof. We observed that the participating psychiatrists applied different mental disorder
concepts pragmatically in different contexts, whilst there were differential effects of different diagnoses and symptoms on the disorder concept employed. The phenomena of practice were grouped in different ways (relating to various theoretical frameworks but also different practical goals), therefore these groupings potentially represent different ‘kinds of kinds’. Judging which kind is appropriate becomes a clinical skill. Based on an assessment of, to put it succinctly, the facts and values present in the phenomena in relation to the pragmatic goals of the encounter, an estimation can be made of the kind of understanding of mental disorder that should be applied, in relation to the facts and values of both phenomena and context.

Brülde (2010) echoes this thought in an article focusing on the purposes of a definition of mental disorder, (based on the assumption that mental disorder is a practical kind), concluding that “it is far from certain that a single definition of mental disorder can help us deal with all the relevant issues. Instead, there may well be a need for different notions of mental disorder e.g., one medical notion that can help us decide who is entitled to health care, and one legal notion that can help us determine who needs to be committed.” I believe it is too early to describe such a perspective as a purely contextualist understanding of mental disorder (cf. Graham 2013), since as mentioned above, more empirical work is required in order to examine whether a representation such as that offered by Haslam could supply coverage for all our understandings of mental disorder. However, for now, I feel justified to conclude that with respect to mental disorder, there is not currently, and we do not expect there to arrive soon, a unifying definition covering all cases observed in practice. This does not imply, however, that mental disorder is a non-kind, and/or that the boundary between disorder and non-disorder is arbitrary. The border is contestable, but decisions can be made on the basis of pragmatic, scientific, and ethical arguments referring to the valuational and epistemic domains that are relevant to the phenomena. The relative contribution and the nature of facts, values and pragmatic goals determine the outcome. Depending on the groups involved of the boundary issue, e.g. patient and psychiatrist versus third-party payer, or family relative versus patient, or professional group versus minister, it is possible that different conceptualizations for the same phenomena are legitimately possible. This view has implications in a variety of areas: for research, for professional practice, and for (professional) representative bodies relative to mental health. These implications will be examined in Chapter 10.

9.3.2. Ethical practice and the ‘good’ coffee bean

The CVZ example may serve to base the second, ethical, argument on, whilst illustrating the potential value of network analysis for localized ethical judgment.
If we return to the ‘CVZ network’ and focus on values and their location, then the values of ‘precision’ and ‘control’ are closely linked to the left side of the diagram. Due to the restrictions of this study, this analysis is synchronic, but a full actor network analysis would encompass a diachronic perspective. Depending on the outcome, the way in which the values of precision and control travel through the network, and how ‘mental disorder’ is translated and transformed in the process, can be evaluated. This is an added, empirical approach to analyzing the ethical dimensions of the concept of disorder. A common feature of mental health practice in recent years has been to protest against bureaucratization and rationalization (Kaasenbrood, van der Werf and Hanneman 2006), phenomena related to technical rationality. A network analysis offers the opportunity of analyzing such a process and thereby attending to factual and evaluative elements. In accordance with Wallace’s admonition previously, and the discussion on ANT, we make no commitments to realism or constructionism with respect to the ensuing mental disorder concept.

What is the value of such an analysis for the individual psychiatrist? At the end of the previous chapter I ended the with a commitment to ‘clinical judgment’ as a foundation for legitimacy of psychiatric practice, understood as a skill of faithfully attending to the facts and values in play within a given context. The question asked there was: what should the scope of such judgment be? How far does one’s professional responsibility extend? Recall the casual example of the first chapter, the question of whether philosophy is as relevant to practice as it is to putting the kettle on. Here this is taken in its ethical sense, related to the normative content of mental disorder. The point here is that this necessarily involves a contextual judgment: no general statement can be made. Let’s extend the metaphor. Imagine I am putting the kettle on, for coffee. There is the question over which coffee beans to use. Say, hypothetically, I’m not terribly aware of the social, ecological and ethical dimensions of the coffee trade, and generally just go for the cheapest product at eye level, or the kind my gran used to make. My ethical reference community (my mates) have no problem with this. However, one sunny day, I bump into an exceptional other, love blossoms and I invite her home for coffee. She, however, has professed her empathy for and commitment to ‘fair trade’. I embark on a brief mission to ethically rebrand my kitchen before her arrival. The mission is a success, and we live happily ever after. My mates congratulate me on my cunning plan, but after a while, with some prompting from my now significant other and a little reading, I find I actually do agree with her point, I just hadn’t thought about it much.

The point here is that we would say, initially, that I am free to choose not to engage in an ethical exploration of the coffee bean. However, once I start to commit to a
certain engagement with another person, or an activity, I enter a different normative context. This context asks for certain commitments, even requires them. In professional practice, there are the professional community, the institutional context, and government guidelines to fall back on as a normative context. But significantly, and emphasized time and again in this study, psychiatrists check with the patient, both on the approach to and description of the problem, and on the preferred way forward. This is not simply a fact-checking enterprise, simple identification, it is checking to see whether there is shared understanding. Understanding involves meanings, meanings involve values. As one participant put it, the psychiatrists hope to ‘have them backing me up’. This normative anchoring is a crucial, foundational, legitimizing process. Being ‘faithful to the phenomena’ also entails the complex activity of attuning the DEF and its contents to the normative context of the patient.

The legitimacy of the ethical decisions of practice also involves comparing the normative dimension of the mental disorder concept to the patient’s own normative reference framework (or ethical community). For practice, as I proposed in the previous chapter, this implies a normative sensitivity: the skill of being aware of the values in play in the encounter in a given context. However, added to this, in this chapter we have noted the possibility of presence of societal values in an implicit mental disorder concept, impinging, as it were, on the encounter. As another hypothetical, let’s say that the values of precision and control are transmitted into practice through institutional arrangements (not so hypothetical in view of the recent history of mental health services). As we have seen previously, individual practitioners differ in the way they accommodate institutional epistemic values in practice: some accede to the institutional constraints, others do not. All are involved, consciously or not, in a normative negotiation and attunement process between society, themselves, and the unique context of the patient.

Patients too could be expected to differ in their own evaluation of institutional values. Some prefer a psychiatrist who takes more time to understand them, others may be quite happy to just take the pills and get back to work. Rather than striving for some unified foundational ethics to judge these matters, the argument for the objectivity of values in the world connected to a sense of judgment in correctly assessing them, provides an alternative form of legitimacy for the professional which is values-inclusive, non-arbitrary, arguably objective, and grounded in clinical expertise. To add to the normative sensitivity argued for in the previous chapter, these include a sensitivity to ‘extra-professional’ sources of value content related to the disorder concept and affecting the clinical encounter, and the ability to relate such values to the values of the patient. On the face of it, this may seem an unreasonable demand: should we now be examining every ‘coffee bean’ of medical
practice? This seems a gargantuan task. However, in fact normative sensitivity includes the skill of judging the *relevance* of issues for the task at hand. The fundamental normative context is pared down by the professional role: the psychiatrist is there for a purpose. The role of the physician may have some historical and contextual variation, but is generally quite clear within a given society. This limits the scope of relevant values. But encapsulated within this professional role is a universally agreed on duty to attend to the potential benefit and harm of one’s involvement as a physician. Specific to psychiatry, and different from general medicine, is the room to conceptualize and attend to mental disorder in different ways. Psychiatrists should try to do this in ways that accord with the ‘lifeworld’ of the patient because this is ethically required in order to judge benefit and harm: this can only be assessed from the individual’s personal value framework. But the values involved in such conceptualizations are not wholly manufactured in the psychiatrists’ offices, and a sensitivity to the ways in which societal and scientific values translate and transform such conceptions should be one requirement of good practice for psychiatrists. What good practice itself should be, is the subject of Chapter 10.
9.4. Main points Chapter 9

- **Actor-Network Analysis** is a useful tool for tracking conceptualizations of mental disorder throughout history across health care, scientific, and social domains.

- Communities with shared views and interests interact to co-create mental disorder conceptualizations. Such concepts are molded both by the facts of the world, metaphysical and scientific views, and social forces.

- No one unified MD concept appears to be historically dominant.

- Specific MD accounts tied to specific disorders or phenomena are deployed in a context-dependent fashion wherein pragmatic sociopolitical goals are influential.

- The size in scope and values diversity of the mental health field should result in increasing heterogeneity of MD concepts in practice.

- As the formation of MD concepts is historically and culturally relative, attempting to validate a current MD through a likeness argument with historically similar phenomena is invalid.

- A minimal consensus philosophical position shared by both the practical kinds and natural kinds views of MD is that its judgment requires a local, contextual perspective.

- Secondly, there is a consensus on an evaluative element within the MD concept. This implies a local value context, and furthermore, democratic requirements with regard to patient values.

- The concept of clinical judgment should be taken to encompass the accurate recognition and understanding of the facts and values in play within the phenomenal field of the physician-patient encounter, including those embedded in language and theoretical concepts.

- The limits to such apperception are given in the physician’s normative charge: the betterment of the patient.