AAPP Association for the Advancement of Philosophy and Psychiatry

Bulletin

Volume 24, Number 1 **2017**

From the Editor

Getting Metaphysical

This issue of the AAPP Bulletin is devoted entirely to Peter Zachar's recently published *A Metaphysics of Psychopathology* (MIT, 2014). The range and depth of the commentaries speak to the multiple questions and issues provoked by the book.

The format of this Bulletin issue is as follows. Peter begins with a summary of the book, providing those who have not read the book but want to follow the discussions a starting point. Next come the commentaries. Finally, Peter responds at length to all of them. As he acknowledges, this exercise has allowed him to rethink many of the issues addressed in his book. Taken as a whole, the commentaries and responses offer a very rich discussion of questions central to philosophy and psychopathology.

One other note regarding the formatting. Inasmuch as Peter Zachar is now President of AAPP, I asked Claire Pouncey, our ex-President, to write the President's Column.

Before proceeding, I want to thank both our commentators and Peter Zachar for the work they have all put into this extended discussion.

One of my strong impressions in reading the commentaries and Peter's responses is that in most cases a dialogue has been initiated that could have continued productively beyond the commentary and response. It is Peter's accomplishment to have initiated so many dialogues. This does, however, put me into a unique position as the editor who has read all the commentaries and responses. I will take advantage of that position to continue one of the dialogues. This one involves the commentaries of Rego, Thornton, Cooper, and myself, along with Peter's responses. At the end of his responses to commentaries, Peter will respond to this continued dialogue. I would suggest that readers save this exchange for later and now proceed with the commentaries.

About Rego Peter writes:

> One flaw of the correspondence theory relates to Rego's notion of the disconnect between our understanding of the natural world and the natural world as it exists. Given such a disconnect, how can you ever know that your concepts correspond to the world as it exists in itself? Is there only one way to correspond? How would you check that the correspondence is there?
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> In addition, how do we know if what our statement corresponds to is indeed a fact? It would be circular to claim that a fact claim is true if it corresponds to the facts. One way to avoid circularity is to allow pragmatic tests and consid

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President's Column

In the last 15 months, there has been a resurgence of interest in a fairly obscure part of psychiatry's code of medical ethics called the Goldwater Rule. The Goldwater Rule specifies that "…it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement."[1] While this proscription is unremarkable in a clinical setting, it intends to prevent psychiatrists from speaking publicly about public figures who exhibit surprising or alarming behaviors. Named after the American Psychiatric Association's [APA] response to the 1964 scandal in which *Fact* magazine informally surveyed 12,356 psychiatrists on the psychological fitness of presidential candidate Barry Goldwater to serve as president. At the time, only 2417 psychiatrists responded, and of those 1189 (just under half) of those responses provided psychodynamic reasons for Goldwater's unfitness. Goldwater successfully sued the magazine for punitive damages in Federal court shortly thereafter,[2] but in attempting to appeal to the refusal of compensatory damages was reminded that the first amendment "giv[es]each person in this country the unconditional right to print whatever he pleases about public affairs."[2] Nine years later, the APA codified that psychiatrists must not make diagnostic pronouncements about public figures.

AAPP's then-past-president Jerome Kroll, MD, and I started criticizing the Goldwater Rule in 2008. We co-presented a paper called "APA's Goldwater Rule: Ethics of Speaking Publicly About Public Figures" at AAPP's annual meeting in 2008,[3] and followed up with a related symposium at the APA meeting the same year with the same title.[4] In 2008, the public figures of interest were terrorists, school shooters, and celebrities with substance abuse problems.

By the time Dr. Kroll and I fully developed our thoughts and published them last June,[6] the words and actions of Donald Trump were the hot topics of public scrutiny. Our paper argues that the Goldwater Rule is intended to protect the APA's reputation rather than the common good, public safety, or the well-being of our patients. We detail limitations of the formal diagnostic interview, we illustrate situations in which diagnoses or "professional opinions" are rendered remotely and unobjectionably as a matter of course, we note the logical inconsistencies between the Goldwater Rule and other sections of the Code of Medical Ethics, and we challenge the APA to specify how and why psychiatrists can/should separate ourselves *as psychiatrists* from ourselves as members of other social groups and roles. In sum, we endorse upholding the Goldwater Rule as a point of professional etiquette rather than ethics, but argue that if an individual psychiatrist has profound concerns about the mental health of a public figure that are thoughtfully, responsibly,

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A Metaphysics of Psychopathology (MIT Press, 2104) Summary

Peter Zachar

Chapter 1: Introduction: Science Wars, Psychiatry, and the Problem Of Realism

In psychiatry, it is common to question whether a given psychiatric disorder is real. In psychology, scholars debate the reality of theoretical entities such as general intelligence, superegos, and personality traits. These concerns raise a further question: what is meant by the abstract philosophical concept of "real?" Indeed, some psychiatric disorders have passed from being considered real to imaginary (as in the case of multiple personality disorder) and others from imaginary to real (as in the case of post-traumatic stress disorder).

Concerns about the reality and unreality of psychiatric disorders are related to larger debates about scientific realism. The passions that accompany discussions of realism are exemplified by the Science Wars of the 1990s. Optimistically considered, the Science Wars resulted in a more nuanced use of metaphysical concepts such as "real" on the part of those participants who were both scientifically and philosophically inclined. Discussions about the reality of psychiatric disorders are even more passionate. An important goal of this book is to encourage an evolution of the use of metaphysical concepts in psychiatry and psychology that echoes what happed in the Science Wars. In this book, metaphysical concepts such as real, true, and objective are viewed in pragmatist fashion as conceptual tools that have an important role to play in psychiatry as long as they are not treated as transcendent, absolute concepts.

Chapter 2: A Scientifically Inspired Pragmatism

Scientifically-inspired pragmatism can be contrasted with the postmodernist-inspired pragmatism of Richard Rorty. The founders of pragmatism represented the first generation of scholars who could experience the theory of evolution as part of their intellectual inheritance. The pragmatism of William James in particular was inspired by a reading of Darwin that was ahead of its time because it did not reject the primacy of natural selection as did the most scientists of the day. Scientifically-inspired pragmatism represents the tough-minded dimension of James' thought, which he called radical empiricism. Radical empiricism is the view that we do not need to look beyond or transcend experience in order to legitimately use "metaphysical" distinctions such as subject versus object or appearance versus reality. Radical empiricism foreshadowed some of the ways that the empiricist tradition would evolve in the 20th century.

Chapter 3: Instrumental Nominalism

According to instrumental nominalism, it is important to conceptualize what collections of particulars have in common, but as the collections grow larger and the concepts more abstract (e.g., Truth), they become increasingly obscure and applied to a contradictory list of instances. There are three ways of making such abstractions less obscure. One, they can be juxtaposed to contrast concepts. Two, they can be decomposed into component concepts. Three they can be stratified into more homogeneous sets of cases. Instrumental nominalism is inspired by Charles Peirce's claim that we are never at the beginning or end of inquiry, but always in the middle. We cannot divest ourselves of metaphysical assumptions, but we can temporarily isolate and critically analyze any assumption in order to make conceptual progress.

Chapter 4: Psychological and Scientific Essentialism

A common feature of essentialism is the belief that discovering the inherent natures of things will lead to a classification system that carves nature at the joints. Some scientific psychologists claim that that essentialist thinking constitutes a cognitive bias. This bias emerges early in our development and continues into adulthood as psychological essentialism. Whether we develop such a cognitive bias, however, is independent of the philosophical justification of metaphysical essentialism – which has recently been powerfully defended by proponents of the new scientific essentialism. Hillary Putnam was an important early advocate for scientific essentialism but with increasing experience came to abandon it. His pragmatist-inspired rejection of essentialist metaphysics emphasizes the various ways that we actively elaborate upon experience in order to acquire factual knowledge that serves our interests and goals.

Chapter 5: Misplaced Literalism

Literalism is the heir of the search for an ancient Adamic language of "true names" in which names and things were believed to be in unity. The conceptual contrast that is of concern in this chapter is "true versus literally true." To demonstrated how prevalent literalism can be in scientific discourse, a list of examples where this distinction can be made but is not always made is followed by a critical exploration the claim that genes are literally strands of DNA. In the field of psychiatry, diagnostic literalism is sometimes referred to as reification. Three different "misplaced literalisms" that occur in psychiatric diagnosis and classification are one, literalism about taxa, two, literalism about diagnostic criteria, and three, literalism about explanatory constructs. All three of these literalisms are supported by our need to rely on authorities when deciding what truth claims to accept.

Chapter 6: Literalism and the Distrust of Authority

A unique feature of modernity is the public expression of skepticism about authority paired with the private realization that it is difficult to know what (and who) to believe. This modern condition is shared by both conservatives and liberals. Different types of authorities in both religious and academic communities are explored, including self-styled prophets, self-taught experts, credentialed experts, and innovators. The chapter ends with an accounting of the extent to which everyone has to rely on communities and recognized experts to know what to accept. This feature of our psychology raises the worry that we are all trapped, not so much behind a veil of ideas, but within the boundaries of our chosen community's beliefs.

Chapter 7: The Objective Within, Not Beyond, Experience

Gaining information about an objective, mind-independent reality while needing to rely on a larger community to know what to accept as true and also remaining committed to fallibilism is challenging. According to radical empiricism, a workable notion of the objective can be found within experience. The experiential basis of the objective is found in the realization that things are not always what we want or expect them to be. The normative claims about our obligations that follow from this realization motivate an important interest in the concept of objective knowledge. The metaphysical concepts of "the objective" and "the factual" are associated with the experience of rationally compelled acceptance. Being *compelled* to accept some claims is an important feature of scientific knowledge, but the experience of being compelled is contingent upon the acceptance of epistemological norms.

Chapter 8: Classification and the Concept of Psychiatric Disorder

A caricature of nominalism, the assertion that "psychiatric disorder" is only a name for conditions that psychiatrists decide to treat, is unacceptably relativistic. One of the most important and persuasive attempts to regiment the concept of disorder in response to such relativism is Jerome Wakefield's harmful dysfunction model. Wakefield advocates for a kind of essentialism. In contrast, the *imperfect community model* seeks to avoid both relativism and speculative metaphysical inferences about essences. According to the imperfect community model, the various symptom configurations that are classified by psychiatrists resemble each other in a number of ways, but there is no property or group of properties that all of them share in common as a class. Turning to scientific psychology, this non-essentialist model is elucidated by describing causal networks as alternatives to the essentialism promulgated in latent variable models.

Chapter 9: Four Conceptual Abstractions: Natural Kind, Historical Concept, Normative Concept, and Practical Kind

The pragmatist's view of concepts as tools that we use for certain purposes is applied to the contrast between natural kind and social construct. Both of these concepts offer informative ways of thinking about psychiatric disorders, but they are more useful when made less obscure by being decomposed into components. The decomposition of the natural kind concept results in five overlapping features: naturalness, inductive potential, existing in a causal framework, carving nature at the joints, and being subject to the authority of science. The most obscure feature is naturalness. The most useful features are supporting induction and causal explanation. The concept of social construct can be decomposed into historical concept, normative concept, and practical kind. A visual figure in the form of a tetrahedron may be used to place some of these concepts in dynamic relationships with each other to emphasize that they can all contribute to a better understanding of psychiatric disorders.

Chapter 10: Can Grief Really be a Disorder?

The debate about eliminating the bereavement exclusion in the DSM-5 was contentious. The public side of the debate (should grief be classified as a mental disorder?) concerned the proper place of scientific and psychiatric authority in society. The academic side of the debate (should depressive symptoms that occur between two and eight weeks after the death of a loved one be considered a psychiatric disorder?) concerned what is to be counted as a *real disorder*. The de facto essentialism adopted in much of psychiatry is contrasted with the more empiricist imperfect community model. From the de facto essentialist perspective, the debate was about how to distinguish the simulacrum of depression that occurs after bereavement from a true depression. From the perspective of the imperfect community model, the debate was about whether some depressions should be normalized.

Chapter 11: Is Narcissistic Personality Disorder Real?

After reviewing the history of the constructs of pathological narcissism and narcissistic personality disorder (NPD), the reasons why NPD was targeted for elimination in the DSM-5 are described. There is disa-

greement about the reasons for its eventual reinsertion: does it have some clinical utility or was it reinserted only for political purposes? The chapter concludes by looking at why constructs such as narcissistic personality disorder are included in the domain of psychiatric disorder. It is argued that competing versions of the essentialist bias interfered with the implementation in the DSM-5 of a competition between categories and dimensions that would have set up conditions in which progress would have had a better chance of occurring.

Chapter 12: Psychiatry, Progress, and Metaphysics

The claim that psychiatry has failed to make progress and gotten on the wrong track by expanding the diagnostic system to include conditions that are not really disorders has become common place. According to this view, much of the imperfect community is a classificatory mistake as a result of over medicalization. The history of what many consider to be the ultimate mythical psychiatric disorder – hysteria - is viewed through the lenses of the historical kind, normative kind, and practical kind perspectives. Hysteria is analyzed in nominalist fashion examining its conceptual contrasts, seeing how it has been decomposed into components, and describing its stratification in recent DSMs. A more pragmatic, less metaphysically encumbered notion of scientific progress is also offered. Progress is made when a new theory or model gains competitive superiority over another with respect to some standard – and is most dramatically seen when we can know or do something that was previously unachievable, even unimaginable. The book concludes by emphasizing the importance of metaphysical concepts such as real and objective for thinking philosophically about psychiatric disorders, urging also, that we think philosophically about these metaphysical concepts themselves.

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Limitations on What We Know Is Certainly "Out There"

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As a non-philosopher with a strong interest in the subject, my first impression of a philosophy book depends not only on its perspective, but on its ability to teach me something. On this point I enjoyed reading Zachar's "The Metaphysics of Psychopathology.(Zachar, 2014)". In addition to the arguments made it serves as an advanced primer on the philosophy of psychiatric nosology. Articles have been written to accomplish a similar goal but end up being lists of terminology without context.

Zachar covers a lot of territory in pursuing his argument. In doing so he takes some side roads into battles over the DSM 5 and other areas of the psychological literature, all to edifying and interesting effect. My small wish list for this book would have been to include a few other terms for examination such as materialism, it's cousin, reductionism, and the matter of concept validity as a central tool of psychiatric classification. But you can't have everything.

For the purpose of this brief commentary I will take up two issues. First is the main subject of the book, and of this review, pragmatism. Pragmatism, in my view, always seems to fall short in fulfilling its expectations as a theory of knowledge. It does the same in this book. I'll explore why and hopefully draw some conclusions about where else to look for such a theory.

Secondly, I will briefly explore an overarching, tacit premise in Zachar's explorations. This can better be described as an extension of Zachar's work rather than a critique.

Zachar's begins with the goal of situating pragmatism within empiricism and therefore within experience. By doing so he accomplishes several things. One is to avoid the poles of nominalism (in this form just relativism in disguise) and essentialism, which veers off into metaphysical assumptions. Another is to locate truth and its associates, objectivity and reality, within what we can as humans experience, measure and use (as opposed to what we can imagine or logically conclude for example).

On first blush this seems like an attractive program. Certainly avoiding extremes is a good policy. My concerns arise when Zachar digs deeper into pragmatism and pursues his goal of situating it into experience only. Here is where I hope for more from pragmatism and find it almost there but not reaching its goals. In particular, I do not find the conclusion of finding all we need within experience more than a diagnosis of exclusion. He promises more, specifically in chapter 7, but I do not think he provides it.

Zachar leans on empiricism, here radical pragmatism (i.e. truth lies within experience) to support his brand of pragmatism. For Zachar Truth (and thus the objective and the real) do not lie "out there" to be discovered. Rather, they are things supported by the evidence. The evidence can be very complicated and highly specialized so we understandably rely on an imperfect community of summaries to inform us.

Throughout the book Zachar uses three types of pragmatism in his discussions; classical pragmatism (a high dependence on practical outcomes), radical empiricism (claims are justifiable by experience alone) and instrumental nominalism (groups of observations or pieces of evidence will generalize into some other useful information). Each type of pragmatism accepts some form of evidence as its form of confirmation. But the argument that the various types of pragmatism accept evidence for different reasons comes up short as it does not describe in each case why some evidence will be useful and other evidence is not. Ultimately this leads to an infinite regress (evidence is useful because it is useful…); things are accepted as evidence but with no end in sight because there is no absolute truth or truth "out there."

With regard to the acceptance of evidence, the first question is, evidence of what? I imagine Zachar and I would agree that the evidence needs to do something. Perhaps it would support a theory that already has other support. Or in more practical terms the evidence would make something work; and experiment or a device. We would seem to be agreeing on pragmatic terms.

However, I think the rapprochement would be short lived as I would say that the evidence reflects an objective truth because it makes something actually work. That is, it corresponds to something "out there." Again, Zachar has no need for the "out there." If there is evidence that gets something done, we can call it true and have no need to go on from there.

All in all, I think it would be better to say that there are problems between our understanding of the natural world and the natural world as it actually exists. One side does not easily map onto the other. This is fundamentally a problem of human limitations and perspectives. Pragmatism seems more like a partial solution rather than a description of the state of affairs.

I agree that absolute truths and things nebulously "out there" are problematic but these are problems with the scope of what we can know and inherent limitations on how we find things out.

Consequently, I do not see this as a metaphysical problem but an epistemological one that goes to the heart of how we know things at all. I would have found it helpful somewhere in this part of the discussion if Zachar had included a description of what a metaphysical view of truth would look like. I would probably agree that it would not be fruitful to try and fulfill the metaphysical view and is not the direction I would go.

So rather than describe this as a problem solved by pragmatism I would look at it as a limitation of how we know things and attribute it to perspectivism. The truth is "out there" but we can never envelope the whole thing and are always biased in our perspective. Furthermore, we have the problem of experimentation where our technology and goals affect the outcome of what we discover. (N.B. I am aware that in quantum mechanics the nature of reality changes to one that is inherently unknowable and not limited only by our own short-comings. This certainly extends the entire discussion but as we do not know if this applies in other places in nature it makes sense to limit our discussion for now).

Zachar is aware that our knowledge is biased and affected by aspects of perspective. It is greatly to his credit that he sees these things as parts of the experience of knowledge and not exclusionary of psychiatric knowledge as some critics of psychiatry would have it. This is demonstrated in his model of the imperfect community. Another excellent example is in Zachar's description of "heaps". These are areas between two poles of relative certainty of, a diagnosis for example, where overlap takes place (e.g. a description of the categorical vs. dimensional problem in diagnosis). In this analogy the "heap" is the point at which a heap of sand takes form after dropping one grain at a time onto a flat pile. These overlaps take place in nature and most areas of knowledge and do not rule out the possibility of making a useful and accurate determination.

Later on he comments on levels of explanation (a level which is useful for teaching may not be useful for a scientist(Kendler, 2012)) and suggests that they are also not exclusionary. I would add values as another important perspective on this list. Values are incorporated into all of our thinking but do not exclude the possibility of scientific knowledge(Sadler, 2002)

To return to the "out there" problem I'd like to introduce the thought experiment of the NASA rocket. NASA readies a rocket for lift off on a Monday. Sadly, the entire human race unexpectedly dies on the Sunday before. Fortunately for NASA the lift off was the first of its kind in which a computer program was set to handle the entire thing while engineers stood by in case of a problem. Now no one is there to watch. The scientific community whose approval and agreement support the principles which have gone into building the rocket are all gone.

We can guess the result. The computer program takes over and the launch goes off as scheduled. What knowledge went in to the successful launch? Not a social conversation (a la Rorty). Nor an agreement that decreases cognitive dissonance. Mind dependency is no longer an option (though one could claim it was when the system was designed). This is in one sense the opposite of a tree falling in a forest. The phenomenon in question (making sound, having a lift off) has already occurred. There is no question of that. The question is, without a mind-enabled participant how can the successful natural phenomenon, engineered by humans, be explained. Things worked because something true was tapped into. Maybe a few theories were untrue and things worked anyway. We know this happens. But in the case of a rocket thousands of assumptions go into place to make things work. Most if not all had to be true or there would be no lift off. We do not know it completely but can test what we think we know. The rocket itself is such a test. To say that we are calling these many assumptions true because they work does not explain the reverse of this statement. Namely, why do they work?

The second point I'd like to briefly take up here is an assumption that underlies Zachar's discussion as well as most discussions within the philosophy of psychiatry. That assumption is that good psychiatry should follow good philosophy. I do not disagree with this. Rather I think that the reverse should be considered much more often than it is. That is, philosophy should follow the facts of empirical findings in both studies and common practice to compose its starting premises. The lack of this perspective gets to the thorniest of our problems. I will look at an example from Zachar's book as an opportunity for philosophy to take a different turn when things don't add up and to illustrate what I mean by this reversal.

The goal here is not a priority of disciplines but a sequence involved in understanding phenomena. Observation comes first, theory follows. In this scenario science provides the observations as it is dealing with things like pathology and experimental results while philosophy adds the layer of models and explanatory theory.

Let's look at the case of psychopathology. Everyone knows by now that psychopathology does not divide up easily. Things exist on continuums and in dimensions, are heterogeneous in their presentations and comorbidity is the rule rather than the exception. Hundreds of genes underlie single diseases and multiple causal pathways (prenatal to later life experience) can bring a person to the same place. Medications lack specificity and have effects that span different pathological states (also true for psychotherapies). Given all this why should we think that there are any joints at which we should carve psychopathology?

Everything we know—which although far from determinative is not insubstantial—suggests highly complex, interweaving networks and pathways. Nothing here suggests that psychopathology exists in rigid, boxed-off categories. Yet we criticize nosology when it does not fit such a model. Rather than criticizing nosology for not cutting nature at the joints we should be exploring models which do not involve joints at all.

By following the findings of psychopathology research and the experience in clinical care, philosophy is

well positioned to generate new models which include these findings. My suspicion is that such models will need to be cross disciplinary, but this is consistent with much of the work in philosophy of mind.

As a bonus for this approach, philosophers would be doing psychiatric research a significant service. Generating data by itself will not, in my view, be adequate for generating explanations for mental function. In fact, recent work in complexity theory has shown that increasing the output of data from empirical studies brings with it an exponential increase in the number of possible explanations for the data in question.(Bar-Yam, 2016) What is needed are overarching theories to organize information. Reformatting philosophical premises to the data at hand is the path to this end.

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Philosophical minimalism and idealism in Peter Zachar's 'A Metaphysics of Psychopathology'

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Although Peter Zachar's book is called a 'metaphysics of psychopathology' its focus is, in fact, broader in two respects. First, it outlines an approach to metaphysical concepts in general, outside psychopathology. Second, the approach to be taken to metaphysics – which following William James, Zachar labels both 'scientific pragmatism' and 'radical empiricism' – reflects a broader approach to philosophical method. The method dovetails with substantial metaphysical claims about the connection between reality and experience. It is not antithetical to advancing metaphysical claims but takes such claims to be advanced within the boundaries of experience rather than attempting to gesture to a reality without them.

> [T]he pragmatism that I explicate in this book is concerned with nitty-gritty issues in the scientific disciplines. Based largely on the pragmatism of William James, scientifically inspired pragmatism has no a priori commitments that oblige it to take a side in metaphysical debates such as those between scientific realists and antirealists. Neither does it deny the value of the substantive philosophical distinctions (such as appearance versus reality or subject versus object) that are explored in such debates. (ibid: 25)
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> Radical empiricism is a view proposed by William James that asserts that experience rests on nothing outside of itself (i.e., neither behind nor beyond all experience). The metaphysical distinctions that we make in order to see how things hang together (such as subjective versus objective) are made using the resources available to experience. (ibid: 239)
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> Radical empiricism is a theory about the sufficiency of experience for making metaphysical claims. (ibid: 52)

As well as this general claim about the experiential limits of metaphysical distinctions, two other ideas play an important role in the machinery of the book. One is Arthur Fine's deflationary approach to debates between scientific realists and anti-realists in the philosophy of the physical sciences. Fine argues that both realists and anti-realists accept a common core. Both sides accept the truth claims made by scientists which Fine calls the 'natural ontological attitude'. But then both interpret these in additional metaphysical terms.

Anti-realists provide a reinterpretation of the nature of such truth claims. This might be a social constructionist account of scientific practice. Or it might be the claim that the truth of a belief consists in its coherence with other beliefs. Such modifications reinterpret the common core. Fine's characterisation of what a realist adds to the common core is simpler: 'what the realist adds on is a desk-thumping, foot-stamping shout of "Really!"'. The reason for this is that:

> The realist, as it were, tries to stand outside the arena watching the ongoing game [of science] and then tries to judge (from this external point of view) what the point is. It is, he says, about some area external to the game. The realist, I think, is fooling himself. For he cannot (really!) stand outside the arena, nor can he survey some area off the playing field and mark it out as what the game is about.' (Fine, 1986: 131)

Zachar summarises the realist side of this disagreement thus:

> What then is the difference between scientific realists and anti-realists? What is the contrast between these two philosophical positions if it is not about what scientific statements are true? According to Fine, the key contrast between the scientific realist and the antirealist is that along with the various considerations that are relevant in accepting as true a statement such as "bipolar disorder has a genetic component," a scientific realist wants, in addition, to assert some special relationship called correspondence to reality. For example, in addition to accepting all the reasons for agreeing that bipolar disorder has a genetic component, the scientific realist stomps his foot and shouts out—"Bipolar disorder really does run in families, *really!*" (Zachar, 2014:51)

A third element of the framework is what Zachar calls 'instrumental nominalism'.

> If we were to specify what all true statements have in common, the result—called the universal essence of Truth—should be fully present in every possible true state-

> ment. Nominalists reject such universals and attend instead to the variability and plurality that exist within concepts such as truth... Instrumental nominalism is the view that abstract metaphysical concepts (which are best defined in terms of contrasts such as subjective versus objective) can be allowed as long as we are clear on the purpose for making the distinction. (ibid: 238)

Zachar uses instrumental nominalism as a means of avoiding hasty essentialist thinking. It fits with the idea that metaphysical distinctions should be tied to experience. For example, although he commends Wakefield's harmful dysfunction analysis of psychiatric disorders as a 'parsimonious, elegant, and useful' his key criticism is that it goes beyond possible experience.

> Horwitz and Wakefield use a conceptual analysis of what we should and should not be expected to do to identify what lies within our biologically designed, naturally selected range of behaviors. According to them, talking to family members without intense anxiety lies in this range, but handling snakes without intense anxiety does not. Only psychiatric symptoms that interfere with what we should naturally be expected to do are to be considered objective dysfunctions. In this analysis the distinction between disordered and normal is being made not by discovering an objective dysfunction but by intuition. The HD analysis cannot, therefore, be reliably used to do what it was proposed to do—*factually* demarcate valid psychiatric disorders from the larger class of problems in living. (ibid: 120-1)

The objection is not that the analysis is false or incoherent. Rather, the appeal to biological dysfunctions to underpin a notion disorder inverts actual explanatory priority. Intuitions about what is and is not a disorder drive judgements about selective history rather than the other way round. So the objection is that the model is a gratuitous metaphysical explanation which goes beyond clinical experience.

Zachar adopts a similarly anti-essentialist view of psychiatric taxonomy in general. Rather than assuming that there must be a common essence behind diagnostic categories, he suggests that the actual pattern of overlapping similarities and differences exhausts the facts of the matter. And hence he commends an 'imperfect community' model of kinds rather than an explanation of kind which dig beneath the clinical surface. A similar approach guides the detailed discussion of particular diagnostic categories in the final chapters of the book.

I think that this is an admirable approach to the philosophy of psychiatry. Explanatory minimalism is a hygienic view of the insight philosophy can provide into other disciplines. In the next section I will outline a different route to the same metaphilosophical approach: Wittgensteinian philosophy. It can seem, however, that it falls prey to an accusation of idealism. I will argue that it need not but then return, in the final section, to ask whether the same is true of Zachar's account.

Wittgensteinian anti-explanatory minimalism

In an early passage in the *Philosophical Investigations* Wittgenstein suggests that a failure to pay attention to the details of language and practice is not simply the result of carelessness:

> If I am inclined to suppose that a mouse has come into being by spontaneous generation out of grey rags and dust, I shall do well to examine those rags very closely to see how a mouse may have hidden in them, how it may have got there and so on. But if I am convinchat a mouse cannot come into being from these
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> things, then this investigation will perhaps be superfluous.
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> But first we must learn to understand what it is that opposes such an examination of details in philosophy. (Wittgenstein, 1953 §52)

Philosophical theory may lead one to ignore practical details because of a prior belief that they cannot be relevant. But, the suggestion goes, the details might contain just what was needed to resolve one's philosophical difficulty.

Cora Diamond provides an extended discussion of Wittgenstein's metaphilosophy which includes an interpretation of this passage (Diamond, 1991). She suggests, following a gnomic comment from Wittgenstein, that the tendency to be blinded to important details by philosophical theory is a mark of philosophical *realism*. This is a surprising remark because, in philosophical debates about the reality of the past, or distant spatio-temporal points, or mathematics, realism is usually thought of as the non-revisionary position, the position which most fits everyday language. Nevertheless, realism fails to be *realistic* when it goes beyond the everyday phenomena and instead attempts to explain them by postulating underlying processes or mechanisms. Diamond suggests that the central ambition of Wittgenstein's philosophy is to be realistic whilst eschewing both, on the one hand realism and, on the other, empiricism.

Diamond uses two examples from outside Wittgensteinian philosophy to clarify the distinction between realist and realistic philosophy. One is Berkeley's discussion of matter in his *Three Dialogues*. Hylas, the philosophical realist, argues that the distinction between real things and chimeras - mere hallucinations or imaginings - must consist in a fact which goes beyond all experience or perception. For this reason, philosophy has to invoke the philosophical concept of *matter* to explain the difference. The presence or absence of matter is beyond direct perception or experience, although perception can provide evidence of its presence or absence. This however presents Philonous, who speaks on behalf of a realistic approach, with an opening for a criticism. Because of its independence from perception, matter cannot explain the distinctions that we *actually* draw between reality and chimeras. But nor, given our actual practices of drawing a distinction, is such a further philosophical explanation necessary. The practical or epistemological distinctions which Hylas can rely on are also available to Philonous without commitment to the philosophical account of matter. The

mouse, in this case, is the distinction and the rags, which Hylas is convinced cannot explain the distinction, are the practical distinctions actually made.

The second example concerns a more recent case of philosophical realism. The distinction here is that between laws of nature and merely accidentally true generalisations. Peirce argues that this distinction must consist in the presence or absence of active general principles in nature. These can be used to explain the reliability of predictions based on laws. But:

> The reply of a realistic spirit is that an active general principle is so much gas unless you say how you tell that you have got one; and if you give any method, it will be a method which anyone can use to distinguish laws from accidental uniformities without having to decorate the method with the phrase "active general principle". Peirce of course knows that there are such methods, but assumes that his mouse - properly *causal* regularity - cannot conceivably come into being from the rags: patterns of observed regularities. (Diamond, 1991: 48)

In both these cases, realist explanation is rejected. This rejection does not depend on nominalist scruple, however. Diamond suggests that closer attention shows that realist explanations are wheels that can be turned although nothing else moves with them. They cannot serve as explanations of what the pre-philosophical difference in either case really comprises since their presence or absence is not connected to the practices which they were supposed to explain. Their presence or absence could make no difference.

There is, however, an obvious objection to such philosophical minimalism which needs to be countered. The problem is that an opposition to philosophical realism might be thought to comprise a form of idealism, anti-realism or social constructivism.

Diamond's account of the realistic spirit has idealist connotations for two reasons. Firstly, and most obviously, she selects Berkeley to illustrate a realistic approach to philosophy. Despite Berkeley's own claims to the contrary, his opposition to matter is not simply a rejection of one philosophical explanatory theory which leaves everything else, including our normal views of the world, unchanged. Instead, he advocates a revisionary idealist metaphysics. Secondly, Diamond characterises Peirce's account of active principles as a 'belief in a connection supposed to be *real*, in the sense of independent of our thought, and for which the supposed regularity is evidence' (ibid: 50). This suggests that the object of Diamond's criticism is the *mind-independence* of Peirce's conception of active principles. In both cases the examples of a realistic opposition to philosophical realism appear to support a form of idealism.

Whilst Diamond's account may encourage an idealist interpretation, idealism is not a necessary ingredient of Wittgenstein's opposition to philosophical realism. What matters in both these cases, if they are to illustrate philosophical minimalism, is the opposition to realist *explanations*. But anti-realist or idealist explanations are just as much to be rejected (cf. Fine's natural ontological attitude). Wittgensteinian minimalism opposes speculative metaphysical explanation and only thus realism (or anti-realism). I will clarify this by examining one further passage from Diamond's account.

This is how Diamond characterises the realist account of matter which should be rejected as unrealistic:

> For Hylas, real existence is existence distinct from and without any relation to being perceived; and so if the horse we see (in contrast to the one we merely imagine) *is* real, it is because its sensible appearance to us is caused by qualities inhering in a material body, which has an absolute existence independent of our own. The judgment that the horse is real and not imaginary, not a hallucination, is thus a hypothesis going beyond anything we might be aware of by our senses, though indeed it is clear on Hylas's view that we must use the evidence of our senses in trying to *tell* what is real. Still, it is not what we actually see or hear or touch that we are ultimately concerned with in such judgments; and this because *however* things appear to us, it is quite another matter how they *are*. (ibid: 47)

This passage contains two characterisations of what it is for something to be real rather than imaginary. One is the claim that reality has 'an absolute existence independent of our own'. The other is that reality goes 'beyond anything we might be aware of by our senses'. It is 'not what we actually see or hear or touch' and 'however things appear to us, it is quite another matter how they are'. Ignoring for the moment the qualification 'absolute', denying that reality has an existence independent of our own - the first characterisation - would amount to idealism. By contrast, the second characterisation goes beyond an everyday affirmation of the mind independence of the real. It presupposes a philosophically charged and revisionary account of perception in which reality always lies beyond our senses. Thus its rejection is merely the rejection of a philosophical explanatory theory and not itself a piece of revision.

Thus a minimalist or realistic criticism of philosophical realism need not succumb to the criticism that it confuses epistemology and ontology. The rejection of realist explanations of the distinction between real things and illusions or between causal laws and accidentally true generalisations does not imply that these distinctions are *constituted* by the discriminations we make, by their epistemology. On the other hand, the distinctions are not matters which lie beyond our ways of detecting them. They are not independent of our practices in that complete and absolute sense. (If this is what Diamond means by denying *absolute* independence, then neither rejection is tainted with idealism or constructivism.)

Does Zachar's pragmatism slight the independence of reality?

In the previous section, I suggested that Cora Diamond's account of Wittgenstein's advocacy of a realistic spirit by contrast with realism can seem to undermine the independence of reality but should instead be construed as a rejection of explanations which go beyond the distinctions made in practice. My purpose in juxtaposing Diamond's account of Wittgenstein with Peter Zachar's framework of ideas is to highlight two similarities. First the similarity in minimalism with respect to philosophical explanations. But second, the danger that the resulting account may *seem*, at least, to slight the independence of reality. Does Zachar also escape that charge?

It is clear that one central *aim* of the book is to avoid such a charge. The first chapter describes the so called 'Science Wars': sociological accounts which may or may not have a debunking relation to scientific claims. On one view, accounts of the resolution of natural scientific disputes offered in sociological terms imply that physical nature itself is socially constructed. Zachar suggests offers a less metaphysically charged rapprochement: "One important realization on the part of some Science Wars participants was that an analysis of metaphysical terms such as "reality" and "objectivity"—terms that are used to theorize about scientific theories—can be critical without being motivated by an underlying hostility to the truth claims of scientists. (ibid: 11)

Hence later, when discussing whether his suggestion that distinctions should be framed within experience and hence forms of realism that go beyond such experiential limits trap subjects within experience, he connects his nuanced view back to his account of the Science Wars. "Does radical empiricism of this sort imply that we are trapped within our own experience along the lines of a philosophical idealism? If so, then we are back to the debates of the Science Wars and the claim that nature is constructed by us, not discovered. According to the radical empiricist, however, we are not "trapped" in experience, and making distinctions such as objective versus subjective or real versus imaginary helps us to understand why. (ibid: 34)

On the other hand, some remarks do seem to slight reality. For example, when discussing facts he draws a distinction – within the experiential realm – between fact and fiction. But he then goes on to say something more obviously metaphysically charged. "What Holmes said to Watson the morning after they dispatched Colonel Sebastian Moran was never a fact, but what Conan Doyle ate and drank on the day he finished *The Adventure of the Empty House* was a fact once, although it is likely no longer even a potential fact because it is not publicly ascertainable. That information has been lost. (ibid: 109)

But the latter remark does seem to be revisionary: a form of anti-realism about the past rather than a natural ontological attitude. (One way to test intuitions on this is to ask whether bivalence applies such that despite no present evidence either way still Doyle did *or did not* eat breakfast that day.) It is one thing to stress the experiential realm when examining philosophical distinctions. It is quite another to limit reality to what is currently experientially – directly or via evidence - accessible.

I think it is unclear whether Zachar successfully treads the fine line between explanatory minimalism and idealism. Take the following example of Zachar's commendation of a coherence theory of truth:

> In philosophical terms, radical empiricism advocates for a version of the *coherence theory of truth*. One of the ideas behind a coherence theory is that what we consider to be true beliefs are important in evaluating new beliefs whose truth is not yet assured. New propositions that seem to readily cohere with what we already believe are going to be accepted more easily than propositions that contradict currently accepted knowledge... Correspondence theories sometimes give the impression that in knowing what is *really* there we get beyond evidence and experience. Coherence, in contrast, works from within experience. (ibid: 36-7)

The contrast case with correspondence suggests that a theory of truth is in the business of saying what truth is: ontology rather than epistemology. But the account of coherence concerns 'what we consider to be true beliefs' or what is 'going to be accepted more easily': epistemology rather than ontology. Putting the two together suggests a shotgun wedding of what is independent of, and what dependent on, human judgement.

Facts, objectivity and the experiential limits of pragmatic philosophy seem to be at the heart of the venture. But avoiding both metaphysical and excess and a shotgun wedding is tricky. Consider this passage on the notion of what is objective:

> The metaphysical concept of the objective, however, is a useful tool for understanding experiences of resistance to preference. The concept of the objective is partly inspired by and reappears with the recurrence of such experiences in one or more members of a community, but it is not constituted by them. Whenever people start talking seriously about *the objectivity* of such things as the Copernican model, the Apollo moon walks, or global warming, the notion that someone's preferences are being resisted is not far away. The resistance to what we prefer is not *The* Objective in an elaborate metaphysical sense. Metaphysical elaborations go beyond their experiential bases, but nevertheless, taking account of those experiences is useful for bringing the lofty concepts down to earth. Something important occurs when the world is not the way we want it to be, but that is a very minimal, even deflated, notion of the objective—one that does not require getting outside of experience. (ibid: 109)

My worry about this passage is that it starts with a notion which is connected to 'the objective' which is that one may wish certain beliefs not to be true and yet nevertheless they are true. This alone does not constitute what we mean by objectivity. It is 'a very minimal, even deflated, notion of the objective' although it is not 'far away' from it. But then the only hint at what would constitute it is '*The* Objective in an elaborate metaphysical sense' which isn't something that Zachar is prepared to set out for the reader. So what is the sense of objective 'that does not require getting outside of experience'? This passage seems to contrast what it admits to be an inadequate account of objectivity with something that is merely beyond the pale according to the metaphilosophical framework of the book.

The same sort of problem occurs in

trying to set out how a diachronic approach can balance the aim of remaining with the experiential with a satisfactory account of mind-intendent objectivity:

> What about the notion that truths about the world are true independent of what we believe about them, and therefore reality is more than what we experience it to be? Is this something that the radical empiricist cannot account for? No—it cannot be that either. Events from the history of science work well here… Taking a historical perspective allows us to see that our past experience was limited. We can reasonably infer that future generations, with their advanced learning, will see the ways in which our current experience is limited. *Reality* is one of the names we give to what lies outside those limits, but that naming occurs within experience as a result of experience. (ibid: 36)

The significant phrase is '*Reality* is one of the names we give to what lies outside those limits'. Who are 'we'? Zachar may mean realist philosophers who mistakenly - or perhaps pragmatically unhelpfully - do not accept the metaphilosophical framework of the book. If so, assuming the truth or pragmatic success of the framework, then that attempt to name what belongs beyond the limits of experience must fail. If, on the other hand, 'we' refers to ordinary non-philosophers, there must be some success in this naming. But what, according to radical empiricism, can be named beyond the limits of experience? And if nothing can, how can the inchoate thought that experience can mislead – which is surely what gives this passage its drama - be captured even given a diachronic perspective? Later he says "One can accept this historically informed inference without imagining a getting beyond the veil of ideas. (ibid: 103) This picks up a repeated theme that it is tempting to think that we are 'trapped' within a veil of ideas or experience or beliefs.

The chapter ends with an accounting of the extent to which everyone has to rely on communities and recognized experts to know what to accept and how this psychological fact raises the worry that we are all *trapped*, not so much behind a *veil of ideas* but within the boundaries of our chosen community's beliefs.

> The modern dilemma is not that we are *trapped* behind a *veil of ideas* and locked into our own subjectivity to such an extent that the objective world is in continual doubt. (ibid: 97 italics added).

> It is important to be cautious about taking the *veil of ideas* metaphor too literally. For a radical empiricist experience is not a veil of distortion that needs getting beyond. According to such an empiricist we can justify making distinctions between subject versus object and appearance versus reality, but those distinctions are made within experience. (ibid: 102 italics added)

> Something important occurs when the world is not the way we want it to be, but that is a very minimal, even deflated, notion of the objective—one that does not require getting outside of experience. (ibid: 109)

In each case, Zachar suggests that it is misleading to think that we are so trapped. But it is not clear to me that he offers enough of a diagnosis of why – despite the temptation to think that we are – we are not. For example, the injunction that it 'is important to be cautious about taking the *veil of ideas* metaphor too literally' suggests that it should be afforded some insight into human predicament, that there is some sort of veil blocking our view of reality. Moving the concern from a Cartesian solitary veil of ideas to a communal set of beliefs does not seem enough of a transformation to yield philosophical ease. Given that Zachar's key idea is to draw distinctions only *within* the experiential realm, the worry that the experiential realm somehow entraps human subjects blocking knowledgeable access to reality surely needs more philosophical diagnosis?

Furthermore, it is not that there are not diagnostic accounts to ease this intellectual cramp. The most familiar is disjunctivism (Haddock and Macpherson, 2008, McDowell, 1982). It holds that there is more to experience than what is common between veridical and illusory experience. When all goes well, what one experiences is the layout of the world. So when all goes well, there is no veil, simply direct access to objective reality. This is not to say that disjunctivism is both without difficulties or the only game in town. But it would be one way in which to begin to think through the issues raised by the very use of words such as 'trapped' or 'veil of ideas'. The package of ideas of which they form a part is mortal poison to Zachar's commendable philosophical minimalism.

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Doing without *A Metaphysics of Psychopathology*

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I think that *A Metaphysics of Psychopathology* stands out as one of the best books in the philosophy of psychiatry written in recent years. Zachar's book asks what it means to say that a disorder is real. I agree with Zachar that this is an important question, and I think he gives us a good answer. But I'll suggest that the pragmatist metaphysical framework within which he develops his answer is unnecessary and unhelpful. In short, I think that *A Metaphysics of Psychopathology* would be even better without the metaphysics. I'll split my commentary into three sections: (1) what Zachar's got right, (2) problems with the pragmatist framework, (3) how to do without metaphysics in the philosophy of psychiatry.

(1) What Zachar's got right

Debates as to whether this or that condition is a real disorder are common, and commonly acrimonious (consider, for example, arguments over the 'reality' of ADHD, Multiple Personality Disorder, mild depression). Zachar shows us how close attention to what is meant by terms such a "real", "objective", and "true" can help to resolve, or more often dissolve, such debates.

Zachar's pragmatism is in part a methodology, and, at this level, I find his suggestions helpful. In considering an abstract concept, whether it be "real" or "depression", Zachar urges us to think as concretely as possible. For example, we can elucidate concepts in terms of their contrasts. Abstract talk of "reality" is easier to keep a handle on if we specify what contrast we have in mind; "real" versus "fake", or "real" versus "artificial", for example.

When it comes to asking whether some condition is a 'real disorder', Zachar urges us to abandon the notion that there is any underlying real distinction that can be drawn between disorders and normality. Jerome Wakefield's popular approach, according to which disorders are harmful dysfunctions, is criticised as resting on essentialist assumptions and as being of little use – our knowledge of the evolutionary past is so limited, thinks Zachar, that to claim that a condition was either adaptive or maladaptive in evolutionary history is no more than handwaving. More positively, Zachar suggests we should accept that the domain of psychiatry is an "imperfect community". The psychiatric domain is centred on those disorders which were first treated by psychiatrists – extreme psychotic states that were seen in asylum patients. Over time, as psychiatry has expanded, more and more conditions have come to be considered psychiatric disorders on pragmatic grounds; other conditions can fairly be considered disorders if they seem more or less similar to more central cases of disorder, and if treatment by mental health practitioners seems worthwhile.

Chapters of the book flesh out Zachar's approach by exploring the DSM-5 debates about grief and narcissistic personality disorder. Zachar sees psychopathology as a messy domain in which symptoms cluster in complex ways. Disorder concepts are abstractions that act to group together individuals whose problems are more or less similar. Useful abstractions (which can be called "real disorders" as an honorific) group patients into classes that do a good job in enabling reliable inferences to made, for example, about prognosis, or likely treatment response. In Zachar's view, more than one classificatory scheme might do a reasonably good job in enabling inferences, and the best classification will likely depend on our interests. Using such an approach, Zachar suggests that at least some grief-induced depressive episodes can fairly be considered disorders, in that it is reasonable to group them with other cases of depressive disorder and see them as requiring treatment. Similarly he holds that some cases of NPD can be considered disorders on the basis that they are similar to clearer cases of psychopathology such as psychopathy or low-functioning borderline personality disorder. Zachar's approach seeks to take the heat out of debates about the reality of disorder – rather than arguing that this or that condition really is or really isn't a disorder, we can switch to considering whether the evidence suggests that putative cases can usefully be classified together, and whether treatment by mental health professionals might prove helpful.

So far, this is all good stuff. But some of Zachar's claims are more problematic.

(2) Problems with Zachar's pragmatist framework

Zachar develops his account of what it means to say a disorder is 'real' within a pragmatist framework. While I find the methodological suggestions that Zachar takes from pragmatism useful, I balk at some of Zachar's metaphysical commitments.

In particular, Zachar commits himself to a coherentist account of truth. The coherentist holds that for a claim to be true means that it coheres with the rest of what we (the scientific community) believe. More mainstream alternatives to coherentism are either correspondence theories ('snow is white' is true iff it corresponds to the facts) or deflationist accounts ('snow is white' is true iff snow is white). Zachar adopts a coherence account of truth because he worries that correspondence accounts appeal to obscure notions of 'corresponding to facts', and imply that truth might transcend that which is humanly knowable. He worries that 'Correspondence theories sometimes give the impression that in knowing what is really there we get beyond evidence and experience. Coherence, in contrast, works from within experience." (p.37)

Zachar is right to say that talk of 'corresponding to facts' is often obscure, but coherentist accounts of truth are also highly problematic. In particular, adopting a coherentist account forces one to adopt a non-bivalent logic. For the correspondence theorist all claims are either true or false (although often we will not know which). For the coherentist, this is not the case. Zachar tells us, for example, that '…what Conan Doyle ate and drank on the day he finished *The Adventure of the Empty House* was a fact once, although it is likely no longer even a potential fact because it is not publicly ascertainable' (p.109). According to Zachar, claims about Doyle's breakfast are neither true nor false. How problematic is it to adopt a non-bivalent logic? I'm not sure. At the moment logicians continue to argue: Timothy Williamson has argued that rejecting bivalence is 'absurd' (1992), others contest this (for example, Pelletier & Stainton 2003, Richard 2000). What is clear, however, is that debates as to the correct account of truth are difficult and ongoing. If at all possible, it would be best if philosophers of psychiatry could avoid committing themselves to particular accounts of truth.

(3) Doing without metaphysics

Zachar has developed his work within a pragmatist framework. I've developed my own work within a realist framework (eg in *Classifying Madness* (2005)). While Zachar and I disagree at the metaphysical level (eg about truth, the nature of reality etc), we agree on many of our claims about the nature and classification of mental disorders. For example, we are agreed that

- There will be a multiplicity of pretty good classifications of psychopathology
- Which classification is best depends on context and interests
- Good classifications support inductions

- Some conditions are likely vague, some dimensional. This needn't be a problem

- Cases of a good category need to be similar in some way – similarities need not be biological, but might be psychological (or at some other 'level')

That we can agree on so much, opens up the possibility that our metaphysical commitments are doing little real work in supporting our claims about the nature and classification of mental disorders. As a matter of biography Zachar's clearly developed his ideas through thinking through his pragmatist commitments, and I've developed my arguments through thinking through versions of realism. But I think we could both have made the claims about the nature and classification of mental disorders that we want to make without depending on metaphysical claims. For example, both Zachar and I agree that there will likely be a multiplicity of acceptable classifications of psychopathology. Zachar uses ideas from Nelson Goodman to support this claim; I draw on John Dupré's (1981) Promiscuous Realism. But instead we could have argued without the metaphysics. In this case an apt comparison with other sciences would have sufficed, and we could have directly supported our claims via a consideration of classifications used in the biological sciences (where a multiplicity of classifications are well-established). Similarly, it would be possible to argue that dimensional kinds can ground inductions via pointing out that metal alloys are dimensional kinds that successfully ground inductions.

Other key arguments of Zachar's could also have been made without drawing on heavyweight metaphysical claims. Zachar has two arguments against Wakefield's account according to which disorders and non-disorders are distinguished because disorders are harmful dysfunctions. First, Zachar considers Wakefield an essentialist, and he thinks that essentialism is committed to objectionable realist claims that, as a pragmatist, he rejects. Second, Zachar also notes that so little is known about evolutionary history that Wakefield's account is of little use in practice. Zachar's first argument depends on many metaphysical assumptions and will be rejected by those with a soft spot for realism. In contrast, Zachar's second argument, that insufficient is known about evolutionary history, makes fewer controversial metaphysical assumptions and, for this reason, is to be preferred.

To conclude, I suggest that whenever possible it would be best for philosophers of psychiatry to do without a metaphysics. Metaphysical claims, for example about truth, or the basic structure of reality, are obscure, difficult, and contested, and philosophers of psychiatry should avoid getting into such disputes whenever they can. Zachar's claims in *A Metaphysics of Psychopathology* about philosophical methodology, and about the nature and classification of mental disorders, should be accepted – but the metaphysics should be rejected.

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Acknowledgements

A version of this commentary was presented at the conference "Does philosophy of psychiatry need metaphysics?" held at Lancaster, UK in June 2016. This conference was made possible by generous funding from Lancaster University and the British Society for the Philosophy of Science. I am grateful for the helpful comments of those present.

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Words and Concepts in Psychopathology

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In his *A Metaphysics of Psychopathology* our colleague Peter Zachar has offered us a rich discussion of core concepts in psychopathology. He structures his argument within a framework of William James' radical empiricism, and he convincingly draws from this framework a perspective on psychiatric disorders that is non-essentialist and nominalist. In this commentary I will begin with questions that challenge his treatment of abstract concepts in the early part of the book, and I will conclude with an argument that, whatever the merit of my challenges, they do not affect his illuminating treatment of psychopathology and psychiatric diagnostic categories in the later part of the book.

In his defense of radical empiricism Zachar seems at times to be fighting a Platonic strawman. In his central discussion of truth, the real, the objective, and the within-experience, I find it easy to agree with his argument but find myself puzzled about who exactly is the adversary. In the beginning of the book he invokes creationism, whose 'truth' is based on a literalist belief in the bible account. He contrasts that notion of truth with the empiricist notion that "the truth of any claim is an inference supported by evidence" (p, 7). In this case it's easy to spot the strawman and agree with the empiricist position. Only bible-thumping fundamentalist argue for creationism. Zachar does provide more challenging examples such as Galileo's discovery of distant galaxies and carbon-14 dating's ability to estimate the age of organic materials – examples in which developing evidence forced scientific opinion to follow the evidence. (For other dramatic examples, see Elizabeth Kolbert's *The Sixth Extinction*, in which two major scientific discoveries – that there are extinct animals and that there have been mass extinctions – faced massive resistance from the scientific community until accumulating evidence broke the resistance.)

Readily and easily agreeing with the argument of empirical evidence, let's now see where Zachar goes with this. First, he finds it more consistent with a coherence than a correspondence theory of truth. Coherence is based on accumulating evidence; correspondence points to a transcendent notion of truth. I think the difference is not as strong as it may seem to be. We agree that the earth is round rather than flat

because overwhelming evidence points to that conclusion. There is a coherence of opinion based on massive evidence. But how different is that from saying that evidence shows that the statement, the earth is round, corresponds to the fact, or reality, that the earth is round. Or to simplify, a coherence of evidence demonstrates correspondence to fact – or reality. And nothing in this, including the word 'reality', takes us out of experience. To say 'it is true that the world is round' is not invoking an other -worldly, Platonic notion of truth. It's shorthand for saying that evidence leads us the conclusion that the world is round. In this regard, Zachar quotes Ian Hacking as follows:

> For example, someone blieves the universe began with what for brevity we call a big bang. A host of reasons now support this belief. But after you have listed all the reasons, you should not add, as if it were an additional reason for believing in the big bang, 'and it is true that the universe began with a big bang'. (1999, p. 81)

Here I again glimpse the Platonic strawman. If I say, 'all the evidence points to the big bang, so I guess the big bang is true', I may be invoking a transcendent standard, or I may just be underlying the first phrase. It all hangs on how language is being used. For each of the out-of-experience terms such as 'reality', the term may refer to a transcendent Reality, or may refer to the in-experience reality that is there in front of us.

In the discussion of truth, Zachar backs himself into a bit of a corner. Citing Nelson Goodman, he writes:

> In comparison to Socrates, nominalists advocate for an anti-Platonic attitude about abstract philosophical concepts such as virtuous, true, good, and free. Consider the concept of true. From a nominalist perspective, the class of true statements forms what Nelson Goodman (1966) called an imperfect community – meaning that there is no property or set of properties that all members share. To be a nominalist is to harbor skepticism about claims such as 'there is a single essence of truth that can be inferred from a set of many true statements. (pp. 41-42)

The problem, now, is that Zachar has actually already provided us with a definition of truth: that "the truth of any claim is an inference supported by evidence" (p, 7). Presumably, then, the imperfect community of true statements, which purportedly don't necessarily have any feature in common, do apparently have a feature in common: they will all be statements supported by evidence.

In this discussion, I may be making much of nothing. I am as nominalist and anti-essentialist as Zachar is, but I am arguing that concepts such as truth and reality may be Platonic, essentialist, and transcendent to experience, or they may not. I am arguing in a Wittgensteinian manner that the meaning of words is in their use, and that in their use these concepts cover a range from the essentialist to the nominalist.

These little cavils all involve the first part of the book. When Zachar moves on to psychiatry, the empiricist, nominalist, imperfect-community argument comes fully alive. He begins with the concept of a mental disorder and recognizes that there is no one correct definition that covers all that we identify mental disorder. Here the concept of an imperfect community fits perfectly. Regarding the diagnostic categories themselves, we know that, despite DSM-5's objections to the contrary in the Introduction to the manual (and the same is true of the earlier DSMs), many clinicians and researchers treat DSM diagnoses in an essentialist manner. Clinicians labor exhaustively and unnecessarily to find just the right category, and researchers carry out endless studies to prove the core biologic etiology of this or that psychiatric condition. How refreshing it is to see diagnostic categories as imperfect communities – psychiatric conditions grouped together for reasons of similar presentation, treatment, and research. The implication of the anti-essentialist, imperfect-community approach is that we can give up on the need to find a core presentation, a core etiology, and a core treatment. This is vastly messier than the essentialist approach, but it is certainly closer to the 'reality' of psychopathology.

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Some Thoughts on *A Metaphysics of Psychopathology*

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I found Zachar's work, *A Metaphysics of Psychopathology,* refreshingly undogmatic, a quality that is in short supply these days both in and out of the academiy. I found myself frequently agreeing as I read the work. But as listing my areas of agreement is unlikely to further discussion, let me go to a few questions I had about the positions outlined, some of which, I think, point to how hard it actually is to hew to the positions Zachar defends.

My first comment is more of an aside, however. Zachar makes central use of the notion of the imperfect community, a concept that seems to share many features, if I may put it that way, with Wittgentein's notion of family resemblances. This latter notion is briefly considered in Neil Pickering's *The Metaphor of Mental Illness*, which has interesting similarities and differences to Zachar's work. Thus Pickering concludes "Our concepts are not fixed: we develop new ideas (such as Pasyeur's notion of vaccination) and new categorizations for things (such as the body or patterns of behavior). And the ideas that our new conceptualizations may lead to can be formulated in testable ways" (Pickering, p. 177). I will leave it up to those whose are more expert than I am in these areas of philosophy to decide whether Zachar's link of pragmatism and nominalism works, and is a more fruitful way of approaching the broader questions. I will say that pragmatism has often been thought to be friendly to a scientific approach to the world, and I wonder if Zachar sees this, as I think he does, as a way of preserving psychopathology, psychology, and psychiatry, as scientific disciplines.

My second point, and one that touches on the difficulties of avoiding essentialism, relates to the role that the idea of a decline in functioning plays in Zachar's argument. Zachar states that declines in functioning "are developmentally unexpected and not a part of the typical course of life" (p.122). The idea is a central one to Zachar as "its objectivity does not depend on speculation about natural functions" (p.122). He goes on to say that declines are objective in two different

senses "They are often intersubjectively confirmable, and denying that they have occurred, although common, is a distortion' and "Second, this minimalist notion is also normative….The affected person experiences declines that *should not* have happened. They are *unwanted* declines. They represent something being *broken.* They are capacity *failures"* p. 122. All italics are in the original.) He goes on to argue "a decline in functioning is not an essence. It is neither necessary for the attribution of psychiatric disorder (e.g., many cases of mental retardation evidence no decline) nor sufficient (e.g., a gradual loss of strength after age thirty is not a disorder)" (p.123).

The advantages of focusing on declines in functioning for Zachar are clear, but his attempt to keep it from being thought of as an essential feature of psychiatric disorders seems less clearly successful to me. He correctly notes that mental retardation often shows no evidence of a decline in functioning. But on what basis then can we consider it a psychiatric disorder?

Zachar addresses this issue in Chapter 11 "Is Narcissistic Personality Disorder Real? " He begins the discussion with a subsection entitled "Two Problems with Personality Disorders" with that section beginning with a further sub-heading "There is no Decline in Functioning" (p. 181). He initially states "a personality disorder is not an intrusive decline in functioning. The category of personality disorder is, therefore, one of those additions to he domain of psychiatric disorders that make the domain an imperfect community" (.181) – and that keep decline in functioning from seeming to be an essential part of the conception of a psychiatric disorder. The problem is that Zachar does not say at this point what it is that he thinks allows us to justifiably include the personality disorders in the imperfect community of psychiatric disorders.

This problem is made more acute when Zachar heads his next sub-section "'Personality Disorder" May be a Label for Unlikable" (p.181). He states that there is at least a suggestion "that the attribution of a personality disorder to a patient is a way of saying 'Your personality—Yuck!'" (p.182).

Zachar then goes through a long excursion on the history of personality disorders, focusing on narcissistic personality disorder, and the complex maneuvering that went on around ways of conceptualizing personality and its disorders in the DSM-IV and DSM-5. In the course of this discussion he notes "Because personality disorders are not declines in functioning, thinkers such as Kurt Schneider (1923/1950) and Karl Jaspers (1923/1963) did not believe they should be conceptualized as diseases" (p.188.) Is decline in functioning sneaking back in as an essential element of a disorder or disease? Potentially in line with this, Zachar goes on to discuss personality disorders, and hypertension, as perhaps being worth clinical attention because they are associated with the risk for other (real?) disorders such as mood disorders, anxiety disorders, or cardiac disease and stroke (p.189).

He goes on to offer "two reasons why personality disorders in general are in the domain" of psychiatric symptoms (p.198). The first reason is just that "they tend to be symptoms that are commonly seen in psychiatric populations" (p. 198), which may seem a little circular or tautological. He goes on to say "second, in some cases, the symptoms that characterize personality disorders represent observable declines in functioning" (p. 199)! He adds "Because the symptoms space of personality disorders and the personality deficits associated with these injuries overlap, the personality disorders are close simulacra of unambiguous personality pathology" (p.199). I would say that most clinicians, and a sizeable body of researchers, would say that personality disorders are clear examples of personality pathology not just close simulacra of it.

It seems that Zachar ends up saying that because the personality disorders share some similarities with the "real" disorders we can include them in the imperfect community of psychiatric disorders. I imagine a similar argument could be made for intellectual disabilities – because they look like the sort of cognitive disabilities people can have after suffering certain injuries, whether from accident or illness, we can consider them to fall within the imperfect community of disorders. I think it might be a little harder to make this argument for autism spectrum disorders, though I don't think it works that well for the personality disorders, though I imagine if we try hard enough we might find neurological disorders that appear after a decline in functioning that look like the autism spectrum disorders. A bigger issue, it seems to me, is that behavioral abnormalities that occur after a brain injury due to accident, or as sequeIae of infection, are often thought of as being neurological disorders rather than psychiatric ones. Perhaps it is enough that they share the space of symptoms so they can be considered disorders, and we can then divide the disorders as we will.

I would think that it might have been preferable to say that they were disorders in their own right, but perhaps it is hard to find a non-essentialist reason for saying so. As it is, they appear to be parasitic on the paradigmatic cases of illness or disorder, which all involve a decline in functioning. This looks as if it comes very close to making a decline in functioning essential – even if we are at times willing to accept something that is "a close simulacra" of a disorder with a decline in functioning. It might have been better, I think, if Zachar had been willing to say that any condition that is clinically relevant in the sense of being something that required treatment, qualified as being a disorder. Hypertension, for example, which as noted above he discusses as a clinically relevant condition, might thus be considered a disorder in its own right, even if a very heterogeneous one, rather than as simply a condition that is of concern because of its link to other pathologies – even if that link is why it is of concern. For what it is worth, essential hypertension is assigned an ICD-10 diagnostic code. Certainly personality disorders, and other disorders that are not marked by a decline in function, seem to be marked by symptom networks of the sorts Zachar talks about in his discussions of depression and anxiety disorders, as long as one does not insist on symptoms representing a decline in functioning. Impairments in functioning seem clearly evident in personality disorders, autism spectrum disorders, and in the intellectual disabilities, and I am not sure that we need to reference evolution or some essential character of human functioning to be able to say this. Zachar is willing to countenance norms, as we have seen, in the establishment of psychiatric diagnoses, and I would think it would be possible in his model to point to better or worse ways of functioning in the world without by that committing oneself to a hypothetical view of

the course of human evolution and its teleological goals.

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Appreciating Perspectives: Another Step Towards Treating Disordered Concepts

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Peter Zachar's book, *A Metaphysics of Psychopathology*, is both fascinating and insightfu. Zachar is able to draw upon resources in both philosophy and psychiatry to help his audience to gain clarity about particular concepts, such as what constitutes a mental disorder. In focusing upon particular questions in the philosophy of psychiatry, Zachar's work calls attention to the many assumptions inherent in what are thought to be facts about psychopathology. Gaining clarity, then, about the concept of say, "mental disorder," is not merely an exercise in semantics. It is also an ontological exercise. Zachar's book goes a step further than simply acknowledging that much is at stake in the ways that particular concepts are employed in service to psychopathology, however. Zachar aims to take steps – indeed, strides – towards resolving a few of the perplexing ontological questions that are at the heart of psychopathology. In this commentary, I will focus upon one such question that Zachar addresses in his book, namely, the question 'can grief really be a disorder?' After presenting the merits of Zachar's analysis of the question itself, I suggest that there is a further dimension – namely, that of perspective-taking – which is missing in the conversation and which, I believe, might help to explain a problem that Zachar's analysis leaves unresolved.

The question 'can grief really be a disorder?' needs a context. First of all, a debate had ensued about how to classify grief as a stress-triggered depression. If grief is a healthy reaction to loss, then it strains credulity to regard the consequent depression as a disorder. Nevertheless, if depression as a mental disorder implies that a person is experiencing particular symptoms over a certain time frame, then it seems as though how a person comes to be in that state is an irrelevant detail that might prevent someone from receiving appropriate intervention. Second, and more specifically, the debate was informed by the classification parameters for depressive disorders already in place. Prior to the publication of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, or the *DSM-V*, in 2013, bereavement was regarded as a special circumstance in which the symptoms of a depressive disorder may appear in otherwise mentally healthy individuals. A debate about whether the bereavement exclusion should be kept surfaced during the composition of the *DSM-V*. Zachar explains that "… in the DSM a depressive episode must be present for two weeks before it can be called a disorder, and that the bereavement exclusion did not apply once the symptoms persist for more than two months …." (2014, p. 162). Hence, Zachar further explains that "the dispute was about what to name cases in a narrow six-week period – after two weeks but before two months" (2014, p. 162).

Prima facie how to classify a potential six-week period in someone's life seems to be a minor dispute. But this dispute is an instance of a more complex problem of discerning both the power and the authority of the psychiatric community, as well as discerning the appropriate limitations to their power and authority. As Zachar notes, "the emotional core of the bereavement dispute concerned both the proper role of science in psychiatry and the authority that society gives psychiatry to declare what is disordered" (2014, p. 162). Indeed, the bereavement exclusion dispute is about reaching a consensus regarding the scope of what is considered to be disordered. Throughout his book, Zachar carefully articulates the idea that mental disorders have multi-dimensions insofar as they are informed by science, social constructions, politics, and history, in addition to being rooted in value systems. Defining and designating what is to count as a disorder is quite an endeavor, even for just a six-week period of time. The goal is also elusive because it is to draw a line in the sand that demarcates those states or conditions that warrant interventions from those states or conditions that are difficult but, nevertheless, part of a healthy mental life. For the sake of simplicity in this commentary, I will assume that what hinges upon the diagnosis of a mental disorder is primarily access to treatment. The idea that reforming the access to (and delivery of) mental health care might weaken the significance of this debate is an interesting one, but it will not be addressed here.

Zachar helps his audience to understand the complexity involved in thinking about mental disorders as historical concepts and normative concepts, as well as through the lens of the ongoing tug-of-war between natural kinds and practical kinds. I suggest, however, that there is a further layer of complexity that needs to be unpacked in order to get a fuller picture of mental disorders and, ultimately, to gain insight into the bereavement exclusion debate. Because psychiatrists diagnose mental disorders, it is understandable that their perspective became privileged in the related issue about what should (and what should not) count as a mental disorder. But these are separate, albeit interdependent, tasks. To diagnose an individual with a mental disorder seems to require a different set of skills and knowledge than what is required to determine whether a state or condition is a disorder in the first place.

To be sure, it might be helpful here to think about the characterization of a mental disorder as a harmful dysfunction, and to return to thinking about a stress-triggered depressive episode, such as a depressive episode following the loss of a loved one. Being able to recognize depression *as depression* seems to be a clear advantage to taking up a third-person perspective. A psychiatrist who is experienced, well-educated, and trained to recognize particular actions and behaviors in a client that are at root in that person's inability to complete everyday tasks has a type of knowledge that often escapes even the client. Furthermore, a psychiatrist is able to give suggestions and to validate the emotions that a client may be experiencing precisely because a psychiatrist is taking-up a third-person perspective regarding each client's situation and experiences. I do not aim to sug-

gest that a third-person perspective provides the foundation for an objective point-of-view, because even third-person perspectives are value-laden and, hence, inevitably biased. But, nevertheless, a third-person perspective has clear advantages in both the diagnosis of, and in the treatment of, mental disorders as harmful dysfunctions.

But shifting to the determination about whether such a dysfunction exists in a person's life is a different matter. Just as a third-person perspective can yield insight into the mental life of a person that even escapes that person's knowledge, so too can a first-person perspective aid in the determination of what ought to qualify as a disorder. The bereavement exclusion debate provides an illustration as to why this is so. For instance, from a third-person perspective, I can discover that a particular person, Mary, has recently lost a loved one; and I can observe Mary's actions and behaviors. But the sources of information about Mary that are available to me from a third-person perspective inform my understanding of Mary's mental life only indirectly, at best. One potentially crucial piece of information that is valuable in this situation is Mary's worldview and how she is processing her loss. Suppose that Mary's loss triggers either an existential crisis, or a faith crisis, for Mary such that she begins to have serious thoughts about killing herself. Ironically, I would not know about Mary's internal, psychological (and possibly spiritual) crisis unless she discloses that information to me – that is, unless she makes the decision to talk with me about what she is experiencing. Therefore, allowing a first-person perspective to have a voice in determinations about what counts as a disorder, or what qualifies as a harmful dysfunction, is neither being whimsical nor irresponsible. Indeed, if mental disorders are to be informative of a person's mental life, then such disorders ought to be determined, in part, by a first-person account, which can give a fuller picture of one's mental life. I propose that a combination of a first-person perspective and a third-person perspective is more informative in determining what ought to qualify as a mental disorder than a third-person perspective alone.

Including first-personal accounts in the determination of mental disorders might be especially worrisome to those who are concerned about over-medicalization. But here is yet another way in which attention to the debate about the bereavement exclusion is informative. For instance, even if Mary may be helped medically, her existential crisis needs to be addressed as an existential crisis. She needs the time and ability to address her shattered worldview and to process the meaning of her loss as it relates to her self-concept. Perhaps Mary can do this on her own, or perhaps she will need help in doing so. In any case, it is interesting that a concern about over-psychotherapy was not a factor in the bereavement exclusion debate. Including first-person perspectives in the determination of mental disorders also does not take away from the authority of psychiatrists in both diagnosing and treating mental disorders. If part of the aim of psychotherapy is for the client to gain self-knowledge, then psychiatry needs to play an essential role in educating the public about mental health. There's no hope for the possibility of Mary seeking out help if either she does not know that help is available, or she does not know that her mental health depends upon her worldview and self-concept.

Ultimately, the *DSM-V* took a middle-of-the-road stance on the bereavement exclusion. As Zachar explains, "the bereavement exclusion has been eliminated, but the manual notes that depressive symptoms may be considered appropriate responses to bereavement, financial ruin, a serious medical illness, and so on" (2014, p. 179). Interestingly, the consensus reached in the *DSM-V* concluded that depression as a mental illness is thought to be "different from these other experiences because the dysphoria and negative preoccupations are pervasive and not anchored to the loss itself" (2014, p. 179). Certainly understanding whether a person's depressive symptoms are anchored in a particular experience does not exclude the possibility that they can become unanchored, and so the elimination of the bereavement exclusion makes sense in that respect. Mary's circumstances might be illustrative of such a possibility, for instance. If it is supposed that what hinges upon a labeling a depressive episode as a disorder is access to treatment, and if it is further supposed that depressive disorders are focused upon the symptoms 'without an anchor,' then eliminating the bereavement exclusion affords people like Mary access to treatment. Zachar concludes that the *DSM-V*'s middle-of-the-road stance in regard to the bereavement exclusion is "an imperfect solution to the debate, but that does not make it a bad one" (2014, p. 179). While I agree that it is an imperfect solution, I believe that it could be regarded as an attempt – albeit unwittingly – to include first-personal perspectives into the criteria for determining mental disorders. In that respect, I would make the stronger assertion that the middle-of-the-road stance was a good solution in a culture that equates treatment with medicalization, and which privileges a third-person perspective in determining what counts as a mental disorder. In sum, Zachar's book makes a genuine and much-needed contribution in the domains of both philosophy and psychiatry, but I hope that it also starts further discussions about these important issues.

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Zachar on Classification and the Concept of Mental Disorder

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Peter Zachar is a consistently interesting, original and admirably clear writer in a complex subject area. I offer a few comments on an aspect of his recent book *A Metaphysics of Psychopathology*. The aspect I'm interested in is his account of mental disorder and its boundary with normality.

In his chapter on classification and the concept of mental disorder, Zachar brings together two fields of thought. One is psychological research into human concepts, and the other is psychological and neuro-psychological research into causal networks. The question I want to ask in this commentary is whether bringing these two fields together helps answer the question 'what is mental disorder'. Zachar suggests that it does. And I shall argue in agreement with him that an interesting connection between the two can be demonstrated which does help

answer this question. This connection, briefly, is that the features which arise in some causal networks are features upon which a judgement about membership in the class of disorders may be based. I start with some exegesis of Zachar's chapter, before proceeding to my elucidation of the connection between the two fields of thought.

Zachar starts the chapter by plotting a course between the claim that mental disorders are what psychiatrists treat (a form of nominalism, he suggests), and the claim that there is an essence which all mental disorders have which makes them mental disorders. Zachar opts for something which lies between these, which he calls the 'imperfect community' account of mental disorder. As he says in the summary of his chapter:

> According to the imperfect community model, the various symptom configurations that are classified by psychiatrists resemble each other in a number of ways, but there is no property or group of properties that all of them share in common as a class.

This bears some unpacking. By *symptom configurations*, Zachar means the sorts of patterns of behaviours and experiences which characterise specific diagnoses. An example of these clusters of symptoms are those to be found in the diagnostic categories of the *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM). Generally speaking, these are lists of symptoms a person might have, and if the person has them in sufficient number and degree, a diagnosis is possible. For example, here are the characteristics by which Major Depressive Disorder (MDD) may be diagnosed using the DSM 5. (I've removed some references to variations relating to children and adolescents and some other material not relevant here.)

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
    1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful).
    2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
    3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase 4. in appetite nearly every day.
    5. Insomnia or hypersomnia nearly every day.
    6. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed 7. down).
    8. Fatigue or loss of energy nearly every day.9. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
    10. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
    11. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

When Zachar says that configurations such as this *resemble each other in a number of ways*, he illustrates his claim with a historical account. In this historical account, he explains how the modern domain of psychiatry came about as various developments in the field took place through the C19th. For example, at the end of the C19th 'the functional disorders of neurology—especially hysteria and neurasthenia—were combined with the functional psychoses and related disorders of the alienists to form a new discipline called psychiatry' (p.124). This combination took place despite the fact that many of the conditions that neurologists treated 'lacked one or both of the highly weighted features of psychosis, namely, decline in functioning and reality distortion' (125). The unification of the field was based rather upon various other overlapping features, for example excessive anxiety and fear (to cite one of Zachar's list on p.125) to be found in both the psychoses and in the neuroses.

It is this shared but diverse symptomatology that supports the idea that all these conditions are mental disorders, rather than a 'property or group of properties that all of them share in common as a class' (as the summary of the chapter has it). The result is a community, but an imperfect community, presumably in the sense that it is not made up of exactly similar members. This is a non-essentialist approach, but it is not a nominalistic approach, because a pattern of likenesses determines membership in the class, and not purely the fact that these are the conditions psychiatrists treat. Zachar suggests that his approach is not dissimilar to the exemplar approach developed by psychologists (Medin, 1989) or Lilienfeld and Marino's Roschian account (Lilienfeld and Marino, 1995). One of the things such approaches allow for is that some disorders – the psychoses – will seem to be better or central examples of the class, compared with others – the neuroses – which will seem to be more marginal examples of the class. The latter will be in what Zachar calls the penumbra of the class.

Having set out Zachar's approach to mental disorder as a class, I now turn to Zachar's second focus in the chapter on classification and the concept of mental disorder, viz. the focus on causal networks. What makes his approach new for this writer is Zachar's link from the imperfect community of mental disorders to the idea of causal networks in specific disorders.

Causal networks have been proposed as an alternative to the latent variable view of psychological conditions (see Borsboom et al. 2003; Borsboom and Cramer, 2013; Schmittmann et al. 2013). As Zachar puts it:

> … [I]n psychiatry and psychology latent variables are interpreted realistically—meaning the cluster of symptoms that constitute depression are considered to be correlated because they are manifestations of a shared underlying psychopathological process. (p.131)

The causal network approach contrasts with this. Zachar illustrates with the example of MDD (I've added the DSM 5 diagnostic symptoms in square brackets):

> … for causal networks the symptoms hold together because they are in direct, possibly causal, relationships with each other. For example, rather than both sleep problems [A4] and fatigue [A6] being manifestations of a single underlying cause [latent variable] called "depression," sleep problems … likely directly influence level of fatigue. In addition, such factors as depressed mood [A1] and loss of interest [A2] are central symptoms, meaning they enter into a high number of mutual relationships with other symptoms in the network. As a result of these connections, when central symptoms are activated, it is more likely that other symptoms will follow. A pathological state of depression would represent the emergence of feedback loops between symptoms that become self-sustaining. (p.131)

What we call depression, then, is not something other than the network of symptoms, underlying it, and causally related to each part of it independently (a latent variable), but rather depression is the network – or at least the network activated to a sufficiently self-sustaining degree.

So, Zachar presents two ideas in the chapter: one is the imperfect community approach to defining mental disorder, the other is the network approach to explaining specific disorders, e.g. conditions such as MDD. There are some striking similarities between the two. For example, psychologists often treat latent variables as a common cause, and it is this common cause which explains why a number of psychological features have the tendency to cluster. This reminds one of the essentialist idea that all mental disorders have something in common which unifies the category. This is not to suggest that this shared thing in the essentialist account of class membership is necessarily a shared cause, of course. But essentialists have sometimes suggested that all mental disorders have a shared causal characteristic. For example, according to Wakefield, what characterises all disorders is a causal relation between a dysfunction and an unwanted harm to which it gives rise (Wakefield, 1992).

Zachar clearly thinks there are links between the idea of an imperfect community and that of a causal network. The link I'm interested in relates to the distinction between disorder and normality.

> The network model also provides some resources for making the practically important distinction between disorders and normality in order to avoid the problem of defining psychiatric disorder arbitrarily as "what psychiatrists decide to treat." With respect to the penumbra of the imperfect [p.136] community, the contrast between disordered and normal is a conceptual elaboration. Rather than making this distinction using a single essentialist criterion such as objective dysfunction, it is more commonly made using a polythetic criterion set (i.e. a collection of conceptual elaborations). … As more of these criteria are met, the more it makes sense to start thinking of a symptom cluster as disordered. (pp.135-136)

What Zachar appears to be offering in this passage are resources for deciding whether a particular causal network is a disorder, that is, a way of distinguishing causal networks which are disorders from causal networks which are not.

I believe Zachar is calling attention to something important here, as I shall shortly try to explain. However, to see what it is requires a little bit more digging. Zachar spells out how the polythetic criterion set for mental disorder, would help us make the judgement that MDD is a member of the class of mental disorders.

> Considerations that are relevant in making the disorder attribution include (a) the extent to which the person has entered a psychiatric symptom network. The most important criterion is the presence of a decline in functioning, although it is not a necessary criterion. Also, (b) those symptom networks that are locked in rather than transient and flexible are also more disorder-like. Additionally, (c) more severe symptoms and more complex symptom networks support the disorder attribution. For distressing psychological symptoms such as anhedonia, (d) if there are compensatory factors that allow the person to continue to function (and flourish) then a disorder attribution is more warranted. It is also important not to limit assessment to a single slice of time because (e) a past history of symptoms and a family history of symptoms alter the base rates and make the disorder attribution more plausible. (p.136)

Now, I must admit that I find a degree of ambiguity in this passage. For there are three judgements it seems to me which various of these criteria might be used to make: (1) The judgement that a person has MDD (2) the judgement that a casual network is present and (3) the judgement that MDD is a disorder. None of these is equivalent to either of the others. A brief look at some of the criteria brings out the ambiguity.

Consider the first sentence of criterion (a). It seems to me that the extent to which a person has entered a psychiatric symptom network is a basis for making the judgement that the person has that particular diagnosis, in this case MDD. That is, that part of criterion (a) helps with judgement (1). But, this is by no means a way to decide whether the person's behaviour reveals a causal network (judgement 2) or whether MDD is a disorder or a normal pattern of behaviour (judgement 3). Likewise, there seems to be an ambivalence in what we can infer from the fact that symptom networks such as MDD are 'locked in' (as in criterion (b)). If, by locked in, Zachar means locked in to a person's behaviour pattern, that is to say characteristic of the person's behaviour over time, then that seems to be a reason for thinking someone has MDD (judgement 1) or possibly that whatever that person has is a causal network (judgement 2). But, not a reason for thinking that MDD is a disorder (judgement 3).

Now consider criterion (b). Though Zachar seems to think that the intransience and inflexibility of networks makes them more disorder like (judgement 3), I think the judgement they actually help with is whether the person's behaviour represents a causal network (judgement 2). Being inflexible and intransient are features of causal networks in general. Based on Zachar's criteria, there are several reasons for thinking that MDD is a causal network. The temporal existence criteria is encompassed, because the diagnosis requires A1, A2 and three or more of the other symptoms of MDD to have been present all at the same time for at least 2 weeks. The inflexibility criteria

would presumably be met by the requirement that A1 and A2 be present in all diagnoses, and in so far as inflexibility also means that there wouldn't be dramatic change over time, the 2 week requirement would contribute to this as well.

But this still leaves untouched the 3rd judgement as to whether MDD is a disorder. Among the criteria that Zachar mentions, the ones that seem to count in making this judgement are the presence of a decline in function (which is part of criterion a) and the presence of factors which compensate for decline in function (criterion d). On these grounds, there are some reasons for thinking that MDD is a disorder. The decline in functioning requirement appears to be met by symptom A2, at least if we hold that taking an interest in things is a characteristic human function or evidence of functioning. Decline in functioning may also be contributed to by fatigue [A6] and cognitive problems such as loss of concentration [A8].

We can leave aside judgement (1) at this point, as it is the relation between judgements (2) and (3) which is of primary interest to me.

But what of the link between these two – between the criteria which support the judgement that MDD is a causal network, and the judgement that MDD is a disorder? I would suggest that the link lies in the causal network relations between the disorder-like features within the diagnosis of MDD. These disorder-like features are not merely co-present but are co-present because of causal connections and feedback loops among the symptoms of MDD. For example, it might be argued that the presence of the criteria for being a disorder within the MDD diagnosis over time is explicable by the sort of causal and feedback connections sleeplessness, fatigue and loss of concentration have with one another and with decline in functioning. Anyone who has spent a sleepless night knows that the resultant fatigue is not simply for the next day, but may last several days; and that fatigue lessens your ability to concentrate – and may be made worse by attempts to concentrate. This causal loop is likely to ensure temporal duration of these features of the network and of a causally connected decline in functioning – that is to say the presence of a feature which makes MDD part of the class of disorders..

We can now see a clear link between the judgements as to whether MDD is a member of the class of disorders, and as to whether MDD represents a causal network.

Are there any threats to this account? I shall offer one, but attempt a defence to it.

The explication of Zachar's ideas being considered relies on causal networks giving rise to features which in turn are to be found to some degree in other causal networks, so that these networks can reasonably be said to be members of the same class. For example, decline in functioning may arise in the causal networks of MDD and of Bipolar disorder and of schizophrenia. But chains of causal connections and feedback loops can be greatly extended, in such a way that they seem to cross boundaries between the disordered and the normal. For example, one might predict the following causal chain would exist: sleeplessness leads to fatigue, which leads to a person being less likely to accept invitations to go out with friends, which may lead to a gradual cooling of the person's friendships and contraction of their circle of friends, which may in turn lead to fewer invitations to go out, which may contribute to the person often being alone (social isolation), which may then contribute to subjective feelings of loneliness.

This extension of causal chains seems to bring with it two problems. First, it brings into the causal network of MDD a state of mind (loneliness) which is not one of the symptoms of depression (not at least one of those in the DSM 5 account). Where in the causal chain from fatigue to loneliness does one draw the line and say that at this point we have moved outside the causal network? There doesn't seem to be any obvious place at which one can draw this line in the causal chain just illustrated. What makes this problem potentially even more serious is that we may want to look into systematic causal and feedback links between MDD and such experiences as loneliness, objective states such as social isolation and socio-economic deprivation, and so on. In short, the causal network approach faces us with a conundrum. On the one hand one wants to make causal connections between MDD and other features of a person's life, but on the other one wants to retain a clear separation between MDD as a causal network and other aspects of life. It appears that it is going to be difficult to have it both ways.

Second, this also poses a threat to the claim that causal networks create features which underpin the judgement that conditions such as MDD are disorders. For causal chains seem to cross very easily from patterns of behaviour such as those found in MDD which are considered pathological, to patterns of behaviour such as those which constitute social isolation and loneliness, which are not considered pathological. This problem is exacerbated by the desire to find causal links between the pathological and the non-pathological.

Is there an answer to this problem? There may be. In a study published in 2010, Cacioppo et al. considered the question what causal relationship could be found between loneliness and depression. Simplifying their analysis without distorting it too much, I hope, their study suggested two things of particular interest here. First, it suggested that statistically, symptoms of depression and symptoms of loneliness were separable contributing to the 'growing evidence for the conceptual, stochastic, and functional distinctions between loneliness and depressive symptoms' (p.458). And second, that while loneliness predicts changes in depressive symptoms, the opposite is not true: depression did not predict changes in the symptoms (if we may so -call them) of loneliness.

How do these findings – and others that may support them – contribute to the question whether the approach to the class of disorder based on Zachar's work is valid? It supports the claim that – as a matter of fact – it is possible to distinguish the state of loneliness from the state of depression. If both are considered to be causal networks (though this is not a claim that Cacioppo et al. make) then there is empirical evidence to suggest that they are separable from one another, i.e. two distinct causal networks. This then supports the claim that Zachar's approach supports a distinction between a state that is disordered, and a state that is not. Given that the symptoms of loneliness are distinct from those of depression, we can assume that the major features of loneliness are not likely to be the same as those of depression and hence loneliness is not likely to have sufficient numbers of the features which make any state or condition a member

of the imperfect community of mental disorders.

One further remark is in order here. It will be noted that the approach derived from Zachar's work in this commentary relies upon empirical findings. There is no a priori presupposition about what features might characterise the imperfect community of mental disorders. They have to be discovered by consideration of the stable, inflexible features of various causal networks such as that of MDD, and other diagnostic categories. In short, this supports a move towards an empirical approach to defining disorder, which is to be found among some recent commentators (Lemoine, 2013). These commentators say that the question of what a mental disorder is, and where it is to be divided from non-disordered states, is a scientific question. The approach described here involves abandoning conceptual analysis of mental disorder in favour of awaiting the results of empirical scientific exploration of specific mental disorder diagnoses.

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When Grief Becomes a Disorder: Pain, Addiction, and the Brain

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In his chapter, "Can Grief Really Be a Disorder?" (2014), Peter Zachar argues that dysfunctional grief is both real and exists as a cluster of entrenched symptoms for clinical depression. I believe that we can do better than this: in this commentary, I agree that dysfunctional grief is real, but suggest that it has an underlying biological signature that should trump a disjunctive set as its definitive marker.

Zachar focuses his discussion by examining the recent debate over whether bereavement should be excluded as a disorder in the *DSM-5* (2013). In some ways, this was a silly debate, as it really focused on a six-week period between the average time course for normal grief and the two months of on-going symptoms required to diagnose a depressive disorder definitively. But the silly debate was standing in for a deeper conversation about who gets to define mental states as disorders: scientific psychiatry or the "folk"?

Psychiatry holds that while emotional pain is a normal facet of human experience, sometimes emotional pain can devolve into a mood disorder. That is, grief *per se* is not a disorder, but when grief meets the criteria for clinical depression, then it has moved from something normal to something pathological. Normal grief entails being sad and ruminating about a loss, but it is also interspersed with positive memories. With abnormal grief, patients can get "locked into" sad ruminations such that they interfere with life functions. In contrast, folk views require that the bereaved must work through their suffering, in a very literal sense. They align grief with physical pain (Radden 2008) and worry that science would pathologize all grief as depression.

The challenge before psychiatrists and "the folk" is to agree upon criteria that move grief from being considered normal to being considered abnormal. The difficulty is that there are no clear criteria. The folk in general do not find psychiatrists' reassurances that they can diagnose the disorders from how the grief symptoms unfold over time comforting. At the same time, both sides agree that the grief symptoms, and whether they demark a disorder, depend heavily upon individual circumstances, so detecting some sort of underlying essential cause for disordered grief seems a fool's errand.

I aim to help with this errand. What we now know about the underlying brain activity in normal grief and pathological grief can help us in determining which cases fall under which heading, without having to rely on unstable and variable patterns of symptoms. Let us start by looking contrasting the neurobiology of unproblematic grief with that of "complicated grief." Normal grief activates the anterior cingulate, the insula, and the periacquiductal gray areas – all regions associated with acute pain processing (Baliki et al. 2010).

It appears that the folk were not wrong in analogizing one to the other. Perhaps, if we could understand the neurobiology of pain, then we could use that to explore the neurobiology of normal grieving. Study of these two phenomena, and how they go awry, could mutually inform one another.

"Complicated grief" refers to grief that continues unabated at least six months beyond the time of the loss. In some cases, grief does not subside as it should. As Zachar explains, the symptoms can become entrenched and the grieving then becomes a disorder. Its principle symptom is a yearning for the missing loved one so intense that it crowds out other wants and needs. Complicated grief also persists long beyond its expected trajectory, which

is exactly how chronic pain behaves as well.

From a biological point of view, complicated grief activates the nucleus accumbens (NAc) – part of our reward system —in addition to (some of) the pain areas mentioned above (O'Connor et al. 2008). This too is what happens in cases of chronic pain. (In contrast, the activity of the NAc is depressed in cases of normal grief, just as it is in cases of acute pain.) Activation of NAc appears to be correlated with the sense of yearning for the lost love, which O'Connor (2008) compares to the craving one finds in addiction (more on this below).

Let us explore the parallel between grief and complicated grief with acute pain and chronic pain more thoroughly. One might reasonably think that a chronic pain is just an acute pain that does not go away. But this is not the case. Acute pains and chronic pains are quite distinct kinds of bodily events, with different impacts on the body and on one's psychology. Chronic pain is represented in different areas in the brain from acute pain, largely because the brain rewires itself with chronic pain. For example, the way the NAc is connected to the rest of the brain differs in chronic pain patients. In normal subjects, the NAc and the insula are highly interconnected, and the insula indicates the appearance and magnitude of acute pain (Apkarian 2012). But in chronic pain patients, the NAc shifts its functional connectivity to the medial prefrontal cortex (mPFC). And, the greater the chronic pain, the stronger the correlation between activity in NAc and mPFC. In other words, in normal subjects, when the NAc is active, the insula is as well, but in chronic pain patients, when the NAc is activated, mPFC responds (Baliki et al. 2010). In short: chronic pain shifts what would be a normal pain reaction to a more emotional one.

Perhaps counterintuitively, when chronic pain patients also experience an acute pain, their insula responds just as normal subjects' do under similar conditions (Bakili et al. 2006). That is, people with chronic pain can experience two distinct types of pain – chronic and acute – and these differences are reflected in differences in their patterns of brain activity. Nevertheless, as a result of the rewiring, NAc activity differs between healthy subjects and chronic pain patients for instances of acute pain, especially during the "relief" phase felt after the cessation of an acute pain. Normal subjects' brain activity signals quite reliably that a reward is coming as a pain ends, but chronic pain patients' brain show activity that reflects a lack of predicted reward. Chronic pain patients are, in effect, disappointed that their acute pain is ending. Of course, they would still have their chronic pain when an acute pain stimulus ends. Indeed, quite often an acute pain covers over the chronic pain. Under those circumstances, it makes sense that they experience no relief when a pain ends.

This change in brain connectivity is a functional rewriting not specific to pain processing, for we see similar effects for monetary rewards in chronic pain patients – their brains show no real response to reward or loss (Apkarian 2012). In other words, chronic pain puts stress on our protective and adaptive motivational systems such that our motivational system fundamentally changes how it operates. And this change in functionality is so large that it distinguishes between normal subjects and chronic pain patients with an accuracy of more than 90% (Baliki et al. 2012). The evidence surrounding chronic pain processing indicates that it is intimately tied to our reward circuitry. Chronic pain thus appears to be a disorder of our motivational/affective system.

Disorder is the operative word, for there are additional symptoms associated with chronic pain, beyond the pain itself. Chronic pain patients also experience neuroendocrine dysregulation, fatigue, dysphoria, diminished physical performance, and impaired cognition and executive function (Chapman and Gavrin 1999). One hypothesis is that the near continuous activation of the limbic areas shifts reward valuation, and these shifts in turn modulate learning and memory (Apkarian 2012). In other words, being in chronic pain fundamentally changes how one thinks, learns, remembers, and feels. Perhaps the same is true in cases of complicated grief.

Interestingly, the same changes that we see in NAc and insula activation across complicated grief and chronic pain also occur in cases of addiction. Could it be that they are all of a piece, and that they are all disorders of our reward system? Many contemporary theories of addiction identify impulse control difficulties as well as compulsive behaviors. Patients with impulse control disorders feel an increasing sense of tension or arousal before committing an impulsive act, and then pleasure, gratification, or a sense of relief at the time of doing the act itself. These types of disorders are generally associated with positive reinforcement mechanisms (American Psychiatric Association 2013). In contrast, patients with compulsive disorders feel anxiety and stress before engaging in some compulsive behavior, and then a sudden release from the stress as they perform the compulsive behavior. These disorders are associated with negative reinforcement mechanisms.

Impulsivity often dominates early in addiction, and impulsivity combined with compulsivity dominates later in the disease. As addicts move from impulsivity to compulsivity, the driving force motivating their addictive behaviors shifts from pleasure and positive reinforcement over to anxiety, stress, and negative reinforcement (Koob and Le Moal 2001, Edwards and Koob 2010). We see a similar pattern in complicated grief: the yearning that accompanies the loss is not one of pleasant memories, but of sadness. We also see a similar pattern in the shift from acute to chronic pain: the patient shifts from being motivated to seek a pleasurable relief to being unable to experience such relief at all.

The transition from normal consumption to genuine drug or alcohol dependence involves includes the NAc and prefrontal cortex (Gilpin and Koob 2008, Modesto-Lowe and Fritz 2005, Gianoulakis 2009, Egli et al. 2012). As discussed above, similar areas are involved in comparing normal grief with complicated grief and in the transition from acute pain processing to a chronic pain syndrome. It does indeed appear that grieving, pain, and pleasurable consumption (and their related disorders) all share the same underlying neural circuitry. All are very complex reactions that stem from our reward circuitry. Our reward system gives us both pleasures and pains. But with unremitting grieving, chronic pain processing, or extended episodes of intoxication, our brain circuitry and functionality change – and change in very similar ways – such that we can become lost in our disappointment

I side with Zachar in believing that science should define disorders. With good science, we should be able to

identify underlying structural biomarkers for psychiatric disorders. While it is true that mood disorders like clinical depression can manifest themselves in a myriad of ways, depending upon the individual circumstances of the patient, we should also expect that each disorder has a definitive set of neural underpinnings. We should use these structures to diagnose and define mental disorders. If we could do so in the case of grief, then perhaps scientific psychiatry and the folk would be able to agree on how to distinguish normal grieving from something pathological. And then they could just debate whether either is something one needs to work through.

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Essential Reading

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The suicide three years ago of comedic genius Robin Williams inevitably prompted another round of what have become the well-rehearsed pronouncements of the psychiatric establishment. Depression, the public is instructed, is "a real disease" whose diagnosis can be established reliably, whose causes are increasingly understood, and whose treatment is usually successful. If only its sufferers would bring themselves to the attention of clinicians (never mind that in Williams's case clinical attention was hardly in short supply), a great deal of suffering and death could be avoided. Unpacking the many presumptions and misrepresentations entailed in this recurring message would require several books. In *A Metaphysics of Psychopathology*, Peter Zachar begins, appropriately, at the beginning: what does the word 'real' in "real disease" mean?

Zachar has, over the past decade or so, become one of the brightest lights in the philosophy of psychiatry and psychology, and his wide-ranging erudition is brought to bear to great effect in the present volume. Although his subject is psychopathology, his book is perhaps more accurately characterized as a primer on the philosophical constructs that are most useful – I would argue necessary – to understand, practice, and teach psychiatry and clinical psychology with a level of sophistication commensurate with their complexities and importance. This monograph is, however, anything but a dry recitation of conceptual esoterica. Zachar's expertise in clinical psychopathology allows him to use multiple personality disorder, bereavement and depression, narcissism, and hysteria, among other psychiatric constructs, to illustrate his philosophical lessons and insights. And although facility in psychology and philosophy would be sufficient for two successful academic careers, Zachar's knowledge of the history of science, evolutionary biology, astronomy, and physics expand both the explanatory and entertainment value of his work. (Any book on psychopathology that includes the sentence, "For example, photons first appeared after the Higgs field broke electroweak symmetry, but they have existed for most of the history of the universe" (p. 149) deserves a wide readership!)

Despite periodic and generally useful digressions, Zachar's mission is clear: "Our purpose is to examine psychiatry and psychology's use of metaphysical concepts such as real, true, and objective; to refrain from assuming that the meaning of these concepts is self-evident; and to not forbid the use of such concepts as the traditional empiricists tried to do" (p. 210). That sentence gives the impression that he steers a middle course between the scientific realists' belief in a knowable, mind-independent reality and the empiricists' allergy to such metaphysical elaborations. While he is respectful of the range of schools of philosophical thought, he leaves no doubt about his own. Drawing heavily on the American pragmatist tradition of William James and Charles Sanders Peirce, Zachar explains and illustrates compellingly with examples his *scientifically inspired pragmatism*, two major components of which are *radical empiricism* and *instrumental nominalism*.

Philosophical categories such as those in the foregoing sentence can be forbidding to readers unacquainted

with them, but in Zachar's hands they serve to bring metaphysical constructs down to earth. Radical empiricism and instrumental nominalism seek to ground abstractions in experience and insist that they be invoked only if they serve to illuminate particular distinctions in particular contexts. Thus, the notion of 'real' (as in "real disease") is only meaningful when contrasted with constructs such as 'fictional', 'imaginary', 'artificial', or 'fake', and is hopelessly obscure in the absence of such explicit contrasts brought to bear on particular questions. Through that framework, Zachar astutely diagnoses where conceptualization and classification of psychopathology can go awry. Specifically, he identifies *essentialism*, a construct whose enormous importance in this context he has played a major role in illustrating in recent years, as a human propensity that lies behind psychiatry's current conceptual muddle.

As Zachar points out, research in developmental psychology suggests that the impulse to consider taxonomy as an exercise in "carving nature at its joints" has deep roots in human cognition. We seem primed to view categories of psychopathology (among many other domains), at least aspirationally, as *natural kinds*, each possessing an "essence" that has been or eventually will be revealed through research. Despite the DSM's explicit disavowal of it, an essentialist bias appears to be both instantiated in and perpetuated by psychiatry's categorical diagnostic system. Any reader who believes otherwise need only accompany a psychiatric team on its rounds in which talk of "ruling out" particular diagnostic entities, and debates about whether this patient has a "true depression" or that one is "actually bipolar," are certain to be heard. Moreover, as Zachar also demonstrates, the most philosophically complete definition of psychiatric disorder currently available – Wakefield's "harmful dysfunction" model – is fundamentally essentialist and thus problematic.

Zachar's well-informed anecdotes regarding the process of formulating the DSM-5 are deeply revealing of a discipline in crisis. Not long ago many expected the imminent arrival of a golden age of psychiatry in which an understanding of the genetic and environmental influences on neural development and functioning would result in the advent of effective therapies tailored to specifiable psychopathologies; in which consensus about the status of psychiatric disorders would result in destigmatization of patients and cessation of internecine conflict; and in which excitement and justified optimism about the field and its accomplishments would attract the brightest and most promising students to careers in psychiatry. Perhaps less interesting in this context than the question of why that golden age has not arrived is the observation that if one were to listen to the psychiatric establishment and its allies, s/he would conclude that it has. Our highly elaborated and reified system of psychiatric diagnosis has indeed resulted in breathtaking profits for the pharmaceutical industry and a robust market for DSM desk references, diagnostic guides, casebooks, and study guides. For patients and the public, however, our age is considerably less golden. Zachar's conceptual tools are not sufficient correctives, but they are surely necessary for the discipline to advance. His book, therefore, should be required reading for all students and trainees in psychiatry and clinical psychology and – especially – for their teachers.

The majority of corrections to Zachar's text I could suggest would be mere cavils. More substantive, however, is an observation about his apparent belief that metaphysical claims regarding the disease status of psychotic conditions merit less skepticism than such conceptualizations as applied to "milder" forms of psychopathology. Although such a stance is consistent with that of McHugh and Slavney and has a certain intuitive appeal, Zachar's pragmatism suggests other possibilities. Specifically, we should take seriously the observations of some members of the "recovery" community that the disease model of psychotic states – contrary to the salutary motives of its proponents – serves to increase stigma and reduce hope, while implying (spuriously but nonetheless compellingly to some) that pharmacotherapies are indicated in all cases despite their ineffectiveness for some and adverse effects for many. After all, as Zachar so articulately reminds us, the question of whether something is "a real disease" is only meaningful in the context of the consequences of its potential answers.

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Let's Get Metaphysical: The Practical Sinificance of *A Metaphysics of Psychopathology*

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In his work *The Metaphysics of Psychopathology* Peter Zachar demonstrates an uncanny ability to bring difficult philosophical concepts ready to hand. I would like to highlight the practical significance of his work for clinical psychiatry and the science that informs it. So long as metaphysical assumptions remain implicit they cannot be made thematic and called into question. Zachar's brand of pragmatism provides conceptual tools to challenge essentialist assumptions that are virtually a matter of common sense. Zachar notes that the essentialist bias leads to two types of error. I will underscore the significance of Zachar's work by exploring the consequences of introducing these errors into the world of psychiatry. A perverse inversion of clinical priorities can take place when a clinician introduces the first type of error, misplaced literalism, into the clinical encounter by treating the disorders delineated in the DSM as if they were natural kinds. The second type of error that Zachar outlines involves dismissing diagnostic constructs as merely fictional if they do not fulfill essentialist expectations. I believe this type of error is having a pernicious impact on the development of scientific nosology and only serves to reinforce the clinical ethos associated with misplaced literalism.

Zachar notes that when the essentialist bias is applied to psychiatric disorders these disorders are considered to be "natural kinds" that have an inherent and invariant underlying nature that determines their properties. When the disorders denoted in the DSM are appropriated with an essentialist bias errors of misplaced literalism will ensue. For example, anyone meeting criteria for the diagnosis of Major Depression would be regarded as "having" Major Depression in the sense of having the same underlying abnormality as anyone else with Major Depression, and this underlying abnormality would be regarded as the cause of the signs and

symptoms experienced in cases of depression. The practical concern to relieve suffering certainly discloses the importance of discerning underlying causes. But, a metaphysical bias that construes the underlying nature of Major Depression as the "real" story of depression tends to discount the signs and symptoms of depression, and the suffering that goes along with it, as mere epiphenomena. Misplaced literalism would then tend to discourage clinical sensitivity to the many ways of expressing, interpreting, and explaining depression. We can see that misplaced literalism discourages what Nancy Potter (2009) has referred to as the virtue of giving uptake in the clinical encounter. Giving uptake involves attending to the patient's values and perspective about the meaning of their experience. The mission of clinical work is first and foremost to reduce suffering and impairment. But, bringing the misplaced literalism associated with an essentialist bias into the clinical encounter runs the risk of needlessly increasing suffering by discouraging recognition of the mental health service user's interpretations of salience. But, the implications of Zachar's work extend well beyond the need to apply scientific knowledge in an ethical, person-centered manner. An exploration of the second type of error associated with the essentialist bias reveals the depth of Zachar's insight. It demonstrates that the essentialist bias does not solely impact the application of a value-neutral science. Instead, these matters go to the very heart of the production of scientific knowledge.

Zachar wants to avoid certain interpretations of science. He specifically wants to eschew a reliance on the type of transcendent experience that defining objectivity as a "correspondence to reality" would entail. But, he does find value in concepts of fact and objectivity that remain tied to experiences of compelling evidence that resist wishes and preferences to the contrary. He therefore finds rigorous standards of evidence and justification to be emblematic of the virtues of scientific practice. To some extent the recent history of the science of psychiatric nosology can be seen to demonstrate just those kinds of virtues. The neo-Kraepelinian revolution in psychiatric nosology that was ushered in with the third edition of the DSM was Kraepelinian in the sense that it assumed that "cases arising from the same causes would always have to present the same symptoms and the same post-mortem result" (Kraepelin 1899). Thus, there was a belief that the diagnostic constructs outlined in the DSM represented "diseases" or the type of "natural kinds" that would live up to essentialist expectations. And, there was a belief that the diagnostic constructs contained in the DSM were valid only insofar as they represented natural kinds. Importantly, Robins and Guze (1970) developed a means of testing the validity of a diagnostic construct. They developed a list of five external validators for diagnostic constructs: clinical description, laboratory studies, differential diagnosis, studies of outcome, and studies of prevalence rates among relatives. A valid construct that represented a natural kind that unfolded in the same law-like manner because of a shared genetically determined abnormality would be validated by all five factors; it would share family prevalence due to genetic factors, it would unfold differently than other disorders because of its unique etiology. It could be confirmed through laboratory studies due to its unique physiological imprint, etc. While the neo-Kraepelinians expected the diagnostic constructs contained in the DSM to represent natural kinds, Robins and Guze developed a means of scientifically verifying the expectation. And true to the virtues of science delineated by Zachar, there was an ultimate recognition that empirical evidence resisted these "natural kind" expectations. DSM disorders demonstrated heterogeneity with regard to heritability, course and response to treatment. The leadership entrusted by the American Psychiatric Association with the development of the 5th edition of the DSM conceded that the diagnostic entities contained heretofore in the DSM were not "valid" in the specific sense of the term developed by Robins and Guze (Regier & Narrow, et al., 2009).

Kendell and Jablensky (2003) underscored the metaphysical "disease realist" assumptions at play in the notion of validity developed by Robins and Guze. The assumption is that a *real* disease is one in which we understand the causal mechanisms behind the signs and symptoms, and validity can be considered synonymous with "delineating a specific, necessary, and sufficient biological mechanism" (ibid). The reference to the *real* here is a nice cue to the metaphysical assumptions at play. It is important to note that while the scientific integrity of the DSM 5 leadership led them to recognize that DSM constructs were not valid; it did not lead them to question the metaphysical assumptions guiding that notion of validity. Instead, it was confidently proclaimed that psychiatric nosology would eventually "carve nature at the joints" (Regier & Narrow, et al, 2009). The take home message being mental disorders are, indeed, real diseases and it is just a matter of time before we discover them. This is, of course, not a matter of scientific evidence but rather of metaphysical faith. It is not clear that phenomena better understood with, for example, the more complex causal narrative associated with the causal network theory could ever be understood in the disease realist terms delineated by Robins and Guze. What if a genetic influence on mental disorder were in turn modified by a social or environmental factor? Even if these influences could be accounted for epigenetically we could no longer expect the diagnostic construct best validated by genetic history to also be best validated by clinical outcome because clinical outcome is impacted by factors other than the genetic blueprint.

Zachar challenges the assumptions associated with a metaphysical faith in natural kinds with his notion of a practical kind. Rather than a world of predetermined kinds out there waiting to be discovered, the world can be carved in a myriad of ways depending upon one's interests. "There is no single best carving of nature's joints that is adequate to all purposes" (Porter and Zachar, 2012). For example, the nosological conception of mental disorders best suited to meet the needs of a research scientist would not necessarily be best suited to meet the needs of a clinician. Kendell and Jablensky recognized that diagnostic constructs that did not meet the needs of a disease realist could still have practical utility. But, their commitment to natural kinds was such that they believed that determining constructs according to pragmatic interests was tantamount to determining them arbitrarily, "As a result, the boundary between normality and disorder has to be decided ar-

bitrarily on pragmatic grounds" (Kendell and Jablensky, 2003). But, if we eschew metaphysical assumptions about "real" diseases, it is possible to turn this type of thinking on its head and instead recognize that the demand that mental disorders be natural kinds may be completely impractical.

The Research Domain Criteria (RDoC) project was born partly out of frustration with the failure of DSM constructs to align with natural kinds. "Perhaps most important, these categories, based upon presenting signs and symptoms, may not capture fundamental underlying mechanisms of dysfunction" (Insel et al., 2010). RDoC is characterized by a distrust of signs and symptoms as superficial and potentially misleading. The belief that underlying mechanisms are fundamental has led to a neurocircuitry first approach to research in RDoC. Cuthbert and Insel (2013) characterize psychiatry as lagging behind other branches of medicine and envision a future in which psychiatry becomes a form of "precision medicine" in which small genetic variations would lead to specific targets for treatment. But, how well can the neurocircuitry first approach tie to the overall clinical mission of reducing suffering and impairment? While the signs and symptoms delineated in the DSM may not reflect specific underlying mechanisms, they are tied to matters of suffering and impairment that do concern patients and the community at large. Wakefield (2014) points out that the DSM therefore contains a form of conceptual validity that the neurocircuitry first approach of RDoC lacks. Cuthbert and Insel (2010) evince a skepticism about the value of scientific research on the subjective experience of illness for the science of nosology. Perhaps accordingly, RDoC seems to eschew the type of qualitative phenomenological and narrative research methods that could reveal what is fundamental, not in the sense of an underlying mechanism, but fundamental in the sense of discovering what is relevant to the concerns of the patients served. The search for the holy grail of a mental disorder that unfolds in a law-like manner on the basis of a specific genetic abnormality may be wholly impractical with regard to the fundamental concerns of patients. More likely, in view of growing evidence of neuroplasticity, empirical research on neurocircuitry will eventually provide enough evidence to debunk simplistic linear models of neurocircuitry development and reveal the need for more complex dynamic models that can account for feedback loops and the role of sociocultural influences (Kirmayer & Crafa, 2014). Whether or not such empirical debunking will result in a recognition that mental disorders with practical significance are more complex than disease realists would expect/demand, or simply jettisoning RDoC for the next great scientific method that will at last discover *real* mental disorders, will depend on the ability to address the metaphysical assumptions made thematic by Zachar.

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Symptomontology

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The Metaphysics of Psychopathology set me thinking about the being of symptoms, the particular constituents of the imperfect communities upon which Zachar proposes to base psychopathological categories. The metaphysical status of the communities must depend upon the ontological status of these particular constituents. Do symptoms exist only in or for the mind of the diagnostician – or mustn't they somehow also belong to the diagnosed mind? Standard medical usage describes objective evidence observed by the physician as "signs" and reserves "symptom" to refer to subjective evidence observed by the patient, but Zachar does not draw that distinction and clearly does not mean to exclude objective observations from his communities of symptoms. He allows for a variety of ways in which something can count as a symptom. They may, but need not, belong to the "world of pure experience" of Jamesian radical empiricism. The reasons for this latitude about the nature of symptoms are obvious enough upon reflection. The physician's observations are, after all, subjective experiences while the patient's subjective experiences are only available for diagnosis through some form of overt expression observable by the diagnostician. Thus observed, symptoms are simply one species of sign in the generic sense of that word. Whether in psychiatry or any other branch of diagnosis, symptoms are *signs* of pathology. What counts as pathology differs from one domain to another – from psychiatry to endocrinology to cardiology to economics, say, and what counts as a symptom within any such domain must vary accordingly and vary still further from one illness to another. Not all signs point to pathology, of course. Traffic signs are

not symptoms, for example, nor is thunder a symptom of lightning. A symptom is a specific *kind* of sign, so an ontology of symptoms must identify their manner of being more exactly. Susanne Langer highlighted the distinctive character of symptoms in a chapter on "The Logic of Signs and Symbols" in *Philosophy in a New Key:*

> There is a fine distinction between sign and symptom, in that the object signified by a symptom is the *entire condition* of which the symptom is a proper part; e.g., red spots are a symptom of measles and "measles" on the other hand, may be one part of a total condition which we associate with another separate part. Thus, a ring around the moon is part of a weather condition, but what it signifies is rain – another proper part – and not the entire state of "low-pressure" weather.(Langer 1953, 57)

(Langer later recognized the need to distinguish between "sign" as designating the genus that includes both symbols and signs as distinct from symbols and therefore substituted "signals" when referring to either natural signs such as thunder or artificial instances such as traffic signs. The danger of confounding the genus with its specific varieties crops up throughout the literature cited here.)

Langer's account opens the way to understanding the ontological status of symptoms and seems quite congenial with the role of symptoms in Zachar's imperfect communities. As signs, symptoms are *semiotic* beings. Their *being* consists in their *meaning* or *signifying*. No sign, whether signal, symptom or symbol, can exist in and of itself. Its significance consists in a reference beyond itself to whatever it means or signifies. Nor can that relation between sign and signified exist in itself. A sign can only *be* significant *for an interpreter*. As Langer puts it, "if there is not one thing meant and one mind for which it is meant, there is not a complete meaning."(55) But there is more than *one* thing meant by a symptom, since a symptom refers to "the entire condition of which it is a proper part," or, in Zachar's terms, the entire imperfect community of which it is a member. That imperfect community may include both signs and symbols.

The diagnostic process is therefore a process of interpretation, an exercise in *hermeneutics*, the art or process of interpretation, which is often characterized as a circular process of reasoning from parts to whole and back again to parts. To understand a spoken or written sentence, I have to interpret each word in light of its role in the meaning of the whole sentence, -- which of course depends upon the constituent words. An unexpected final word or phrase may require a drastic revision of my original interpretation of the opening of the sentence.

The "hermeneutic circle" does not often close with understanding a single sentence, however, since the meaning of a sentence usually depends upon how it functions as part of a larger whole: the paragraph or stanza or conversation in which it occurs – and that, in turn, will usually depend upon some wider context -- an entire conversation, novel, legal statute or love affair, for example -- or the course of development of an illness. Successful interpretation often also depends upon understanding the source of the signs in question – be it an individual speaker or an organ of the state or of the human body, which will require further enlarging the hermeneutic circle, which may have to be further enlarged to take account of social, historical or ecological circumstances. Where the circle remains open, the interpretation must remain tentative.

An illness is not a text, however, and the pathologist does not seek the sort of coherence that we expect in a sentence or a paragraph, a sonnet or a statute. On the contrary, diagnosis may well depend upon discovering some incoherence among the symptoms and seeking a pattern or meaning for that incoherence. Moreover, the model of textual interpretation does not contend with the fact that the symptoms of illness may include both signs and symbols and that the most significant symbols may not be linguistic. Arthur Danto explores non-verbal symbolism in "Symbolic Expressions and the Self,"(Danto, 1998) where he focuses attention upon the different hermeneutic roles of signs and symbols by drawing a contrast between self-manifestation and self-expression. He illustrates the difference by calling up an image of an egregiously disordered room and argues that if the disorder merely reflects the family culture in which the occupant was raised, it is only a causal manifestation that "expresses nothing about the owner's personality." (56) But if the occupant has chosen the disorder as a protest against conventional feminine stereotypes – or as an adolescent rejection of the "fake, detested values of his terrible and hypocritical bourgeois parents,"(57) the room can be recognized as a symbolic self-expression.

> To distinguish symbolic expressions from manifestations requires that we recognize how the former demands an interpretation, itself at the border of the kinds of interpretation that works of art exact. A manifestation merely requires an explanation. German theorists draw a distinction between *Verstehen* and *Erklaren* – hence between interpretation and explanation. The distinction was to facilitate a division between the so-called human sciences and the natural sciences. But my distinction overrides that, if outwardly the same thing is either manifestation or expression and explained or interpreted depending on which it is. "(58)

Danto thus links manifestations to signs whose meaning derives from causal relations. as in cases like thunder and lightning or smoke and fire. Both signs and symbols may serve as symptoms, since diagnosis engages both explanation and interpretation, which therefore poses the problem of balancing or integrating these two forms of signification, a problem aggravated by the fact that, as Danto stresses, the same overt symptom may be either an expression or a manifestation, "but possibly never both at the same time nor in the same way."(55)

Psychiatrist and anthropologist Arthur Kleinman meets this problem head on in "The Meaning of Symptoms and Disorders," the opening chapter of *The Illness Narratives (*Kleinman, 1988), where he describes how the interpretation of all symptoms as manifestations of causal relations transforms illness into disease:

> Illness problems are the principle difficulties that symptoms and disability create in our lives…. Illness complaints are what patients and their families bring to the practitioner…. The healer – whether a neurosurgeon or a family doctor, a chiropractor or the latest breed of psychotherapist -- interprets the health problem within a particular nomenclature and taxonomy, a disease nosology, that creates a new diagnostic entity, an "it" – the disease. Disease is the problem from the practitioner's perspective. In the narrow terms of the biomedical model, this means that disease is reconfigured *only* as an alteration in biological structure or functioning."(4 - 6 *passim)*

Psychiatrists who hope that neurophysiology or genetics will solve the problems of diagnostic taxonomy seek to realize just such a hermeneutic transformation of illness into disease. Kleinman's book is primarily concerned with chronic illness rather than psychopathology. Even so, he complains that, "In the practitioner's act of recasting illness as disease, something essential to the experience of chronic illness is lost; it is not legitimated as a subject for clinical concern, nor does it receive an intervention." (6) To put the matter in Danto's terms, the translation of illness into disease ignores self-expression and confines the community of symptoms to signs that manifest causal relations between the sufferer and his or her physical world. Of course, this promises to simplify the tasks of diagnosis and taxonomy by eliminating all symbolism from the field of symptoms, which conveniently forecloses the hermeneutic circle. But in so doing, the diagnostician abstracts from the facts that the sufferer belongs to a family and community who apprehend and report the experience of illness in terms supplied by their culture and the ways in which the illness itself may play a symbolic role in the relations of a patient to himself and to his social world. Kleinman analyses several levels of meaning in illness, beginning with the meaning of symptoms *as* symptoms. His analysis is far too lengthy and subtle to summarize here. For present purposes, it must suffice to focus on his contrast between two models of interpretation. On the one hand: even the superficial significance of symptoms qua symptoms is embedded in the meanings and relationships that organize our day to day world, including how in interaction we recreate our selves. This makes of even superficial symptoms a rich metaphoric system available for many kinds of communication.(16). On the other hand, is the semiotics of diagnosis: "For the practitioner, the patient's complaints (symptoms of illness) must be translated into the *signs* of disease…. Diagnosis is a thoroughly semiotic activity: an analysis of one symbol system followed by its translation into another…(16)". As a result, practitioners "not trained to be self-reflective interpreters of distinctive systems of meaning….are led to believe that symptoms are clues to disease, evidence of a "natural" process, a physical entity to be discovered or uncovered."(17)

At this point, the hermeneutics of symptoms converges with Zachar's metaphysics of psychopathology, since the translation of all symptoms into signs entails the essentialist metaphysics of mental illnesses as natural kinds that Zachar seeks to replace by a more Darwinian, evolutionary model. What counts as correct or successful interpretation depends on the interpreter's purpose. Reflection on the criteria of reliable interpretation originally developed in response to the challenges of interpreting sacred texts and legal documents. The purpose of psychiatric diagnosis poses rather different challenges. Zachar's insistence upon the pragmatic character of diagnostic categories places the link between correct categorization and therapeutic purpose in the foreground of inquiry. That therapeutic purpose recalls us from general reflections on semiotics and hermeneutics to the specific nature of symptoms as signs of *pathology*, which entails that the aim of interpretation is to identify or classify *failures* – dysfunctions or unexpected diminishment of functions. As noted above, that means that one cannot count on coherence of meanings as a reliable criterion of successful interpretation.

Moreover, if we accept Zachar's account of psychopathological categories as based upon "imperfect communities" of symptoms, then the "entire condition" in which the symptoms participate and to which each symptom refers is not an available whole so that here, too, the hermeneutic circle cannot be closed and diagnostic categories must remain tentative Furthermore, the meaning of each symptom is liable to be as dependent upon the symbolic or causal context whence it arises as a jurist's interpretation of a statute depends upon precedent. the particulars of the case at hand and the legislative history of the statute. But whereas the purpose of legal interpretation is to issue in a determinative verdict, therapy aims to transform the community of symptoms in question so to eliminate the deficit.

Finally, the therapeutic purpose of psychiatric diagnosis precludes closing the hermeneutic circle in any case, because the diagnosis is not simply a cognitive conclusion, finding the right universal to fit the available evidence. The diagnostic category functions as a hypothesis rather than as a verdict. It enters both symbolically and causally into the therapeutic process and thereby may provoke or cancel further symptoms that thereby change the imperfect community and may require revision of the original diagnosis, much as the end of a sentence requires reinterpretation of the beginning. For decades, psychiatrists interpreted schizophrenia as a deteriorative disease, so that if a patient recovered, the diagnosis must have been mistaken. But studies by John Strauss and others showed that that diagnosis was a vicious circle that had misled therapeutic responses to psychotic patients.(Strauss, 2014) If the outcome of an illness is hopeless, therapy can offer no more than symptomatic relief. Yet even that "verdict" alters the symptomatic "whole" and hence the significance of the symptoms. The individual's response to various psychotropic medications and to other therapeutic interventions—may also prompt changes in the interpretation of particular symptoms – and thence of the whole. Therapy thereby absorbs diagnosis into a dialectical or dialogical process consonant with the evolutionary model of explanation with which Darwin displaced the appeal to natural essences and which frames the beginning and ending of Zachar's book. An imperfect semiotic community of symptoms invites comparison with the interbreeding populations of organisms with which Darwin replaced the enduring species of traditional biological taxonomy. However, a taxonomy of pathologies seeks to identify and

ameliorate dysfunctional patterns or complexes of symptoms rather than successful adaptations, so that therapy might better be compared with artificial selection directed by normative aims rather than with the aimless course of Darwinian natural selection. Yet in both cases, the displacement of timeless essences by temporal processes challenges the task of diagnosis, as Zachar comments in the conclusion of Chapter 10:

> With a diagnostic category, psychiatrists freeze a particular symptom configuration and abstract it away into a type or kind. This allows them to ask how this kind came to be, to describe it thoroughly, and to develop expectations of what might happen to it in the future. When thinking in terms of the abstract type, they ignore the flow in which it was initially embedded. Mental health professionals are often perplexed at how a case of depression can start to look like a case of generalized anxiety disorder and still later seem to be more like a case of obsessive-compulsive disorder, but like clouds in lava lamps, that is what symptom networks are sometimes like. (Zachar, 2014 175-76)

Indeed, the flow of symptoms is essential to the therapeutic purpopse. Insofar as therapy succeeds, it must dispel or alter undesirable symptoms, thereby changing the available population of symptoms, which means that the very purpose and process of therapy conflicts with those of achieving a stable essentialist taxonomy. Attention to the ontology of symptoms thus places the metaphysics of psychopathology in a fresh perspective that prompts a reconsideration of the enterprise of psychiatric nosology by bringing the problem of meaning into the foreground of attention.

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Cognitive Neuroscience, Discourse and the Nature of Psychiatric Disorder

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Peter Zachar's in depth and comprehensive analysis of the science and metaphysics of mental disorder is a welcome stimulus to further discussion and clarification of psychiatric nosology and its scientific basis in an era where the RDoC framework is influential in the philosophy of psychiatry and psychiatric research. In fact the debate echoes the work of John Hughlings-Jackson (JHJ) at the end of the 19th and beginning of the 20th century in championing the relevance of neurological science to a scientific theory of mental disorder. As such, an exploration of the relation between the neural and the mental is timely.

Evolutionary neurology and mental science.

John Hughlings-Jackson's evolutionary neurology began with the stance that states of mind are properly analysable by examining higher order patterns of neural integration in the light of their evolutionary significance (1887). He portrays mental processes as higher and more inclusive levels of representation (and re-representation) to construct a complex repertoire of responses to our human environment. The coordinated activity of a whole organism is thereby related to abilities to over-ride reflex (mechanistic) sensori-motor connections by using learning and integrative neural inter-connectedness to create behavioural responses to patterns of stimuli with ethological (not a term in use at his time) significance. For example, if a child is confronted by adults who often make unpredictable and distressing responses to what he or she does, then the development of normal human behaviour and attitudes towards others will be disrupted. The longitudinal series of dynamic interactions, moderated by speech, from which a human being abstracts a structure of "propositionising" (composing meaningful utterances and thoughts) about the events concerned, produces centres constituting "reservoirs of energy" and "resisting positions" in neural connectedness (1887, 32). These are constituted in part by "structures of nervous energy organised according to word meanings."(1878, 323) Alexandr Luria, the great neuro-psychologist, agrees: "higher mental processes are formed and take place on the basis of speech activity"(1973, 93-4); speech, we could say, derives the information we introduce into the control of our behaviour from our shared (intersubjective) world where human beings construct and exchange tricks or strategies and go on to devise coordinated courses of action in the light of reason and truth.(Mercier & Sperber, 2011)

Thus human mental function, in JHJ's words, becomes "the least automatic", and most integrated complexification of sensori-motor activity (1887, 41) supremely orchestrated by the frontal lobes and their pre-motor association areas (Franz & Gillett, 2011) and hugely influenced by the ways in which we talk to each other and make sense of what we are doing.

JHJ notes that "propositionizing" (or language-related activity), and ongoing problem-solving and goal related plans and strategies (mediated by Dorso-Lateral Pre-Frontal areas) cannot happily be localized and we have now learnt to display the integrative and distributed activity characteristic of that wider cognitive platform especially in the (human) cognitive neuroscience of action (Roskies, 2010). The same widespread integration and coordination in human cognitive neuroscience emerges in several human cognitive functions that elaborate simpler animal capacities.

Human memory is a catch all term for a whole series of processes that include learning, procedural skill development, semantic memory, autobio-

graphical memory and source memory. It fluidly or dynamically reconstructs and consciously draws on past experience to inform present behaviour (Gillett, 2008, 84ff). The relevant neural capacities not only enact similar problem-solving routines (adjusted if necessary for variations) but also allow directed revisitation of past action contexts through off-line processing. In human beings these skills use "representations" that combine the meanings of words (JHJ) with mnemic residues including limbic and paralimbic activity (Freud, 1986, 445-8) and a record of past activity so that we indwell subjective/intersubjective histories that can either straitjacket or liberate the subject from the effects of the past and a present set of conditions.

Emotional resonance with others adds to reasoned and conscious control of behaviour strategies of coordination that, once again aided by speech, use information about the feelings and behaviour of others to organise "centres whereby the organism as a whole is adjusted to the environment"(1887, 34). Human agents take into account the intentions, plans, needs, vulnerabilities and moral demands of others (based on this intersubjective resonance) as, for instance, when I realise that a person to whom I am talking has been deeply hurt by a friend of mine and subtly acknowledge that fact.

JHJ notes the pervasive influence of words in our semantically informed processing assemblies: "Words are required for thinking, for most of our thinking at least but the speechless man is not wordless; there is an automatic or unconscious service of words"(1878, 323). This unusual stance, for an evolutionary theorist, is prescient of two major Twentieth century thinkers – Luria (mentioned above) and Ludwig Wittgenstein, whose famous claim "meaning is use"(1953, #43) is also prefigured by JHJ; "an utterance is or is not a proposition according to how it is used"(1879, 210) such that "superiority of speech is precision of application to new relations of things"(1879, 218). JHJ here indicates the "complex of cues and connections" arising from speech-related activity (Luria, 1973, 306) noticing that word meanings relate contexts of action to the communication that so influences our shared human lives.

The integration and connection of the present moment to experiences remembered, conditions not present, and human conversations place each of us in a unique trajectory enabling both personal integration over time and discursively mediated coordination with others through speech, storying, and imagination, the currencies of human mental lives. These become central not only in human social cognition but also in action, intention, and personality formation as each of us adapts to our shared world of opportunities, subtle awareness of dangers (physical and mental), and the need to become somebody through combining intellect, appetite, and action into a unique sustainable life among others. The action of these broad factors that must be integrated in any human being's response to a situation or series of events depends on real top-down control of lower levels of neural processing by the patterns at the highest level that have become attuned to our complex social reality and most express our individual modes of coping with the world by intelligent participation in it (Gillett and Liu, 2015).

Objective facts and neuro-rationality (these days).

John Locke, in seeking to relate the human condition and human understanding to the science of his day, remarks: "Words in their primary or immediate Signification, stand for nothing but the Ideas in the Mind of him that uses them, how imperfectly soever, or carelessly those ideas are collected from the Things which they are supposed to represent". (Locke 1689, [1975], 405). Linking Locke's analysis to a representationalist philosophy (according to which we are only directly acquainted with the contents of our own minds or brains), implies that the relevant ideas interpose between the mind and the world so that our thoughts (or the propositions we understand) relate only indirectly to actual objects and lose their direct grounding in a shared, objective, world. But the need to closely relate human adaptation to a genuinely ethological understanding of our function requires a more grounded and embodied form of objectivity than that provided by indirect representational realism and it also offers a more penetrating analysis of mental disorder.

An intuitive philosophical response to this threat to objectivity and a natural or well-grounded account of our being-in-the-world is to assert a causal link between mind and world so that our meanings are derived, in a systematic way, from the causal connections mediated by our sensory systems. The trick is then to spell out how we should conceptualize those causal connections to account for the selectivity and intentionality of perception. Straight causal impingement will not do as a theory of perception because of the active top-down editing and construction of experience through multiple and complexly inter-related layers of possible meaning in any human situation. These different layers meet in our shared moments where the possible meanings brought to the situation by different people are "quilted" together to produce a nuanced responsiveness between them (Gillett, 2016). But that "quilting" implies already multiply articulated layers of meaning rather than merely causally and contingently connected situations and unified, coherent, representations apt for truth.

The idea that truth is affected by a selective articulation characteristic of language such that it only partially reveals the world (and even obscures significant aspects of the world as seen by some of us) is a corollary of philosophical views linking sense to different collectives of language-using subjects in which those subjects learn to deal with the world through the great mirror of a propositional structure and its cultural realisation in human contexts (Gillett, 2015). That broader view undermines any simple debate between correspondence and coherence views of knowledge and truth. Given that our dealings with things occur in a real and shared world about which we communicate, this analysis undermines the view that the way a thinker thinks of an object is always and only a function of a particular way of thinking about that thing (as might be held by social constructivism), even though it does allow for the role of diverse experts in a philosophical understanding of semantics. It also makes room for collective mistakes and linguistic change, innovation, or discovery. Consider, for instance the term "electron" - arguably, conceiving electrons as small negatively charged particles at the outer reaches of atoms

and of negligible mass (a view that might have sufficed for classical physics) is sufficient to understand the term even though it is not really true, a fact that raises two normative problems:

(i) who sets the standard for what counts as understanding a given term;

(ii) how can one can successfully refer to an entity and claim understanding of it even though one's understanding of the term being used is largely mistaken or metaphorical.

These problems make it tempting to adopt a collectivist view such as:

The sense of a given term is given by the ways of thinking about that thing accepted by the group of people who count as rule-makers for the meaning concerned. (Call this *The Rule Maker claim*.)

The Rule Maker claim entails that a privileged group defines just which subset of the truth conditions count as grounding the correct use of a given term. So that:

(a) collective discourses recognise experts who dictate the contents of terms used to express knowledge;

(b) such experts can hold a coherent cluster of beliefs arising in their own cultural (or sub-cultural, e.g. scientific) practices; and

(c) the collective practices of talking about an object define what we notice and can think in relation to the entity concerned and together provide a maximally intersubjective conception of the target object.

However there is room in the analysis for the touch of the real to intrude in such a way as to modify or force a reconsideration of the conception of the phenomenon being referred to that is in play. Thus the analysis, cashed out in terms of human discourse and the idea that concepts are tools for rendering the world in ways apt for well-adapted cognitive systems in a discursive milieu, undercuts any simple-minded debate between those who claim that scientific discourse pictures or corresponds to the world and those who claim that science is a culturally inflected construction that obeys only its own rules of internal coherence. We are, instead, forced into the view that our scientific concepts present the world in ways suited to our interests and practices and may function hegemonically if misconstrued according to the stark traditional bipolarity of correspondence-realism and social construction.

Causality and biopychosocial production: the case of hysteria.

Hysteria is a case in point where changing science has shifted the conception of the disease from a wholly mental or spiritual problem to a neurological, to a non-neurological, to a bio-psycho-social or discursive analysis with implications for disease production, maintenance, and nature (Gillett, 2009). In fact hysteria is a perfect stalking ground on which to hunt for the metaphysics of mental disorder.

Imagine a young middle aged man who cannot move his left side when conscious but can when partly disinhibited by a short-acting anaesthetic. The type of phenomenon at the heart of this clinical scenario became of intense interest during the debates about spiritual and natural causes of mental disorder in the latter part of the Nineteenth Century. The spiritualists believed that disease without a biological basis was a proof of the immaterial nature of the human psyche whereas the naturalists (or positivists) believed that all behavioural manifestations must be caused by physiological mechanisms in the human body (Hacking, 1995, 163). Charcot and Freud opened the way for neurological explanations of mental disease but their legacy was tainted by poor science and their own highly tendentious forerunner to "a thoroughly functionalist view of the soul"(Hacking, 1995, 216). In the new era of cognitive neuroscience as the fount of all wisdom, we can try and explain what is going on in terms of changed patterns of inhibition and excitation in the young man's subcortical emotional and motor pathways and thereby finesse any attempt to locate the young man as a human being in an ethological context part of which is "a widely diffused, all pervasive system of thought in which doctor and patient acted"(Tomes, 1994, 361). We can however, take seriously the situated discursive nature of the young man's adaptation to a demanding world and its sometime distorting effects on human relationships.

That realisation prompts an examination of discursive formations as the basis of the explanation of certain characteristic patterns of excitation and inhibition in neural circuits (Gillett & Harre, 2013). We are led to ask why he has developed a conversion reaction (a translation of emotional and interpersonal stress into a quasi-neurological presentation) and what is sustaining it? The resulting enquiry is broadened beyond the neural sphere. When we subsequently find out that he had his "left sided stroke" when trying to account for his being in a car at a well-known trysting spot with a woman who was not his wife, and that his wife was overbearing (to say the least), we might get closer to the understanding we need and begin to glimpse a formulation leading to a therapeutic response to his quasi-neurological disorder (the "dissociation" or "disruption" in his psyche). We should perhaps ask, "Under what strains is he trying to translate his bodily state into a self-report and what positions are open to him in this complex moral-emotive-interpersonal and culturally loaded discourse?" This contrasts markedly with Zachar's discussion of hysteria. Within his view that a "symptom network is also embedded in networks of personality traits, networks of normal cognitive abilities, emotional states, and social and cultural networks"(166) personality style (heavily "cognitivised") and pragmatism about the disorder as it presents yield a sparse formulation of what is troubling the hysterical personality and what could possibly be so distressing as to lead to suicide. Psychology, and hence psychotherapy, is *deep*, and here that does not mean neuroscientifically arcane but deep in a personally and morally troubling way for a caring human being.

Discursive explanation explores the reality of human souls as beings-in-relation who do things to each other with words and demand certain accountings of each other. In this they read what is happening in part from their interpretations of events going on in their own brains and in part in terms of their social and interpersonal skills. In the normal course of events they do not stumble very much in that task, exercising techniques they have learnt to map a situation and their neural response to it onto a structure of shared rules that positions us within "the common behaviour of mankind"(Wittgenstein, 1953, #205). Allowances are made for disability and

illness that draw on the discourses structuring medical life and biomedicine as a system within which both doctor and patient experience and act in relation to what is (pathophysiologically) causing distress and dysfunction. By contrast, the discourses of the soul, lay bare the significance of events to the individuals concerned in personal and socio-cultural terms. A story must be made out of the meanings discerned according to the rules we use to interpret each others' behaviour and it must ring true to the human situation. These two different layers of understanding are necessarily related because of our embodiment but the discursive story reveals a person's self-positioning or self-presentation in the midst of expectations in terms of language games where, among other things, we evaluate each other and react accordingly. A discursive account of the psyche allows us to "distinguish among events … differentiate the networks and levels to which they belong, and … reconstitute the lines along which they are connected and engender one another" (Foucault, 1984, 56) so as to place our reactive and responsive doings appropriately within human ethology and interpersonal life.

Foucault's phrases are pregnant with meaning: events are moments in the enactment of a story; they contribute to our understanding of how people interact with each other and influence each other. The diverse ways that statements engender or connect to one another reveal the (influential even if patchy) narrative production of a person's life. Why has this man got a "left sided stroke" and what has to be done to relieve the (non-arterial/psychic) "blockage" causing it? An assessment of useful interventions and investigations now takes on a quite distinctive profile focusing on life skills, emotional wounds, and relationships within an intense discursive context. The distressed human being who comes to us cannot do this work himself and we must help him see and negotiate the domain of decision (Bolton and Hill, 1996) where we face up to and, one hopes, learn to give reasons for our choices and actions and take responsibility for what we do. That moral or value based dimension to the work of psychiatry is never far away even if the neural "fit" between a person and their discursive milieu may be profoundly affected by a physiological or cognitive "shift" (Bolton, 2008) e.g. in cerebral synchrony.

The impairments of the wayward husband and others like him can be "lost in translation" because their "neurological conditions" have a discursive significance – they are supposed to tell us something even if the message is markedly effaced. The person at the heart of the disorder cannot be as they are expected to be and the inability or mismatch is partly explained by the rules (including moral rules) that govern treating and assessing neurological disorders and those suffering from them. Their disabling breakdowns cannot be dealt with by insight or reflective self-examination and the underlying causes and realities escape them. If that sounds unconvincing, try holding your arm flexed and fist clenched until it goes numb and then move it and feel what afflicts you. This auto-experiment helps bridge the gap between consciousness of the self and a conversion reaction (Gillett, 2009). The intense "pins and needles" (or, for some of us, "searing pain") is neurally generated and as we experience it we link it to a story – voluntarily entering into an auto-experiment as a normal person. Imagine you are otherwise, you feel helpless and hopeless and a minor injury has further unsettled you; you cannot bring yourself back to your normal embodiment and your pain or neurological state is a vindication. We could say that you are enervated or alienated from your familiar lived bodily experience, it is experienced as a cognitively impenetrable breakdown within you and so conveyed.

Scientifically informed practice with real people.

Real people constantly translate brain states into an account of themselves using skills produced in an ethological setting that is embodied and discursive and where the training has been both caring and good enough. The events befalling us and our bodily experiences related to them are, as a result, normally and typically smoothly translated into self-reports. That smooth translation can break down because of loss of properly functioning neural circuits that adapt us as whole organisms to our discursive world or because of the world itself "screwing you up" and making the state of yourself unable to be acknowledged or properly made sense of in terms that you can effectively cognize and live with. Zachar's study of essentialism, realism, social constructivism, and the metaphysics of mental disorder allows us to re-examine the subject of psychiatry philosophically and therefore, if our philosophy is up to it, both existentially and thematically. Zachar gives us philosophy, traditionally framed, but does not really give us existential inquiry. We are notoriously bad at looking awry at our ability to translate from our individual indwelt, neural, *innenwelten* to our storied lives via the many culturally nuanced connections between language and our being-in-the-world, in part because "What is mirrored in language I cannot use language to express."(Wittgenstein, 1962, 42e) and in part because what language reveals about me must be able to be indwelt by me.

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Mentality and Ontology of the Lifeworld in Psychopathology

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I thank Dr. James Phillips for his invitation to participate in the discussion of Dr. Peter Zacher's book *A Metaphysics of Psychopathology*.

It is not necessary to insist on the present importance of the thematic field approached by Zacher in his text, both for psychopathology and for all human knowledge. In fact, he explicitly points to it in the war between philosophy and science started at the end of the 19th century, persisting until today.

Zacher's position throughout his text is always measured, avoiding a fall into the absolutist reductionisms so frequent in the 20th century in all the items included in the field of psychopathology: reality, truth, discourse, experience, certainty, verification, speculation, issues of the concrete and abstract, of being and existence, of the absolute and relative, of description or interpretation, of objective data or theoretical inferences, etc., etc. All that at the end of the last century in which several epistemological revolutions have occurred and in which paradigms have shifted somewhat in all the sciences. All this nonsense becomes even more confusing in the field of psychiatry, a discipline of recent origin in both knowledge and practice, exercised over a system –human behavior– surely the most complex field of things, facts and events of the universe we know. Let me indicate in passing that the study of human life involves physics, chemistry, biochemistry, biology, ecology, semantics, symbolism, social and cultural history (both at the social and individual levels), and evolution of "mentalities" as different forms of grasping the world and oneself. And this last as a maturation process both of humanity and of each individual in his psychologic and cognitive development. This is a theme to which Zacher dedicates several passages.

I emphasize that the maturation of the individual, in the way of understanding, thinking and feeling the world, is the fruit of the maturation of the organism –especially the brain– but also of the maturation of one's personality, mentality, and attitudes.

No wonder that this new discipline of psychiatry, so diffuse and profuse, of so many well or poorly integrated dimensions, appears even today so confusing. Something that clearly exposes this situation is the fact that we still don't have a clear concept of mental illness or pathology, at least not one with adequate consensual agreement. This failure accounts for some of the urgent problems facing our specialty at ethical, procedural, and epistemological levels. Thus for example, the ethical problem indicated by Zachar of deciding when a state of sadness or sorrow passes from being a normal fact of human life to constituting a state of illness. Or the enormous, current epistemological problem of comorbidity, also analyzed by Zachar in relation to all the "ontological dualisms" of the *different anthropologies* underlying in the different psychiatric schools or positions. An example thereof would be Ionesco's book *Catorce enfoques de la psicopatología (FCE, México, 2001).* What is the ontologically "dysfunctional" level at which each mental or psychic pathology is originates? There is a serious procedural problem of where to search for the basic alterations of the psychopathologic structures.

This question includes the "mereological" problem of discriminating differential characteristics between the whole and the parts of an entity – a problem highly topical in all the contemporaneous sciences and one that has been very well emphasized for the field of psychiatry in the book about *Neuroscience and Philosophy: Brain, Mind, and Language* by Bennett, Dennet, Hacker and Searle. I am interested here in highlighting the overarching importance of this theme for settling the character of psychopathological symptoms. Are they "signs"? Mere indications revealing an underlying illness? Or are they rather parts of a deconstructive process that constitutes the psychopathology? This last has been indicated by several authors, for some time now, among them by Juan José López Ibor (Senior), in his book about "Las Neurosis como Enfermedades del Ánimo", p. 139.

This is also the position I will assume in this commentary, addressing the ontological foundations of psycho-

pathology, along with the "mereological conflicts" that are part of the deconstructions of psychopathology. As an initial clinical/ pragmatic framework for my attempt to clarify the "mentality-ontology" relation as a ground of the psychopathologic deconstructions, and of their comprehensive difficulties, I indicate some data from clinical practice.

Is the destructive aspect of phobias the panic in front of the phobic object or situation? Or is the avoidant behavior based on an impossibility of taking possession of the resources of the world for realizing the own life? The dramatic element in agoraphobia patient is not so much the insecurity experienced in a public space, or the panic attacks that can appear in it! The dramatic element is that the individual cannot take possession of the immense spatial atmosphere available for living well and realizing the major part of her life activities.

On the other hand, is the reason for phobic panic the present factual aggression of the phobic object, or is it the "physiognomic figure" of the object and the ideal concept of the category to which the object abstractly belongs? The answer is obvious from clinical experience. A fear or phobia for dogs is not the panic in the fact of a dog actually attacking one. That is fully normal in life. The phobic experiencing panic in front of a dog, even a photograph of a dog, is reacting to the *expressive figure,* to the *physiognomy* that makes imaginarily present the essential threat for him of the species dog.

In another area, is the pathologic element of a manic phase in bipolar disorder perhaps the feeling of total wellbeing, of exaltation of mind, and of expansive mood? Is the destructive element the affective state of happiness, or is it rather the biographic consequences of his unmeasured and *inappropriate* behavior with respect to his world and with respect to the own resources that occur in the manic phase?

And in a major depression, is it loss of the joy of life that predominates in the melancholic mood, or is it the conviction that one's personal life is threatened by the inaccessibility of resources or possibilities for realizing them in this world? It is undoubtedly this last, as Glatzel indicated, and that appears confirmed in Cotard syndrome.

Finally, is not anxiety, the most frequent and ubiquitous symptom of psychopathology, perhaps less an experience of "threat to the self" than a destruction of the active subject in constituting his own human identity?

From these few clinical examples, I postulate that mental illness is a destruction or threat of destruction of the identity of the living individual, stemming from a disturbed, 'in-appropriate' structure of behavior – understanding that the identity of a human being is the result of self-construction through behavior 'appropriate' to one's own reality and to the reality of one's circumstances. "The emancipation of the biological and psychic functional symptoms in front of the personal whole does not involve, in its becoming personal, a disorder? Perhaps the fundamental disorder of neurosis?" As Gebsattel indicated already in 1953.[1]

My objective in this text is not to develop this entire field of inquiry. I have already done that in a "general psychopathology" (*Fundamentos Antropológicos de la Psicopatología,* Ed. Polifemo, Madrid, 2006), as well as in a "regional psychopathology" (now in press). My objective here is only to present this problem in relation to Zachar's book.

For this goal to indicate the origin of psychopathology as deconstruction of behavior, and at the same time as the origin of the problems of exploration and knowledge of psychopathology, I start with what Zachar presented in his Chapter IV about "Psychological and Scientific Essentialism".

Zachar rightly indicates the relation of the *essence* of something to its "identity", to what it *really is*, what specifically constitutes that something as such. And he shows from his review how this relation of the permanent identity of something with "an empirically non-verifiable essence" constituting it is present not only in philosophy, but also in all the sciences, including current microphysics. In my judgement the problem of essentialism lies in the "type of essentialism" evoked in each type of knowledge, and that implies different ontological conceptions that support different types of identity of the entities of the universe.

Thus Zachar indicates the characteristics of the *adult conceptualization* of the structure of essentialism, studied by the psychologist Nick Haslam, among which I underline the following: *Homogeneous and uniform – Naturally occurring – Has necessary identity–determining features – Possesses inherent, underlying properties – Unchangeable and immutable – Stable across time and culture.* These dimensions of essences are the constitutive of the "substantialist ontology" of Western thought from the Greeks up to the 20th century! And it is that of Western adults. It is not even that of children, it is not even that of other cultures, such as the Eastern.

This metaphysic horizon of perception of the being of entities has lived on since the Greeks as a vision of the essential identity of all entities, underlying their sensory appearances. This is a vision of essences as adynamic, permanent, non-material, and eternal vision of the identity of the entities, supported in that non material essence, under all not essential and changing characteristics of the entities in time. This essentialist conception of the being is shared by two variables of Greek thought, the Platonic vision of the essence as Idea, and the Aristotelian vision as Form.

This perception and conceptualization of the being of what appears to us in our surrounding, including human beings themselves, was at origin of the concept of *phyysis*, nature. This meant that the things were not perceived any more as being manifestations or fruits of the actions of *supernatural* beings, but as being things in themselves, based on their *substantial* essences. (Thus was the origin of the substantivation of the verb *to be* as *being*, which did not exist in early Greek). This substantialist ontology of classic Greek thought constituted a great overcoming of the previous "magic-mythic" mentality, and the beginning of the development of the logical knowledge of the onto-logy of the *physics*, as *meta-physics* and as *episteme*. This inquiry into the *being* of existing things through the instrument of reason, came to be called *logo*s (idea, word, criterion). It was the rise of *critical knowledge*, in face of the old mythic -religious dogmatism.

This substantialist metaphysical horizon constituted the ontology at the origin not only of philosophy and science, but of western culture itself. It perceived entities of nature not only as being each "for itself", but also as being something "*in it*self", isolated from its environment. This is the perception that supports the experience and the concept

of something as *real being*. From this vision entities would maintain relations with other entities according to the constitutive essence of each type of entity. Essential relations between entities would fundamentally be of two types: *causal relations* between entities or *composite relations* among the individual entities, whose properties would be the summatory result of the individual entities. Thus Zachar underlines, quite rightly, the privileged role of causal relations. While such causal thinking might be thought of as an innate tendency of human beings, epistemological criticism has shown that this way of thinking has existed only in Western adults, and only from the 5th century until the end of the 19th century.

This atomistic, objectivist, ontological vision, prevailing in all cognitive theories, whether idealist or empirical, is the origin of almost all the conflicts of the contemporary knowledge as well as of the war between science and philosophy. This is better understood if we realize that this vision is not only applicable to the factual or material relations among the entities, but also to the structure of knowing between humans and things. On the one hand, empiricism has understood the phenomenon of knowledge as the result of the action of objects of the world on the senses of the human being. The organs of the senses would be passive, and the action of things on them would produce data of the objects of the world, creating a *representation* of the external object within the brain.

In the case of "idealism", knowledge would be the product of the human spirit or of universal reason, the essence of the human as "rational animal". The object of consciousness would here be an "abstract creation", recreating the reality of the external world from the power of reason, without possibility of true access to reality itself. In both cases the objects perceived would be products of a unidirectional causal action, be it material action in empiricism, or action of the thought (the spirit) in idealism. Indeed, the cognitive result in both cases would be an artificial object with the appearance of being something real in itself. In current terminology, this is a reification of the object. In the case of empiricism an inferential reification, in the case of idealism a deductive reification.

This substantialist ontology, applied to the field of somatic medicine, gave rise to the vision of disease as a deterioration of the structure of the organism by an external, environmental cause. Applied to psychiatry, it gave rise to the vision of madness as a loss of the human essence, of reason. And in a materialist vision, it was seen as a loss of the "rational functions" of the brain, necessarily attributed to genetics as the only basis of the neural structure of the homo species. Following from the genetic paradigm in force in the last decades – gene → protein → (brain) function → behavior -- "the gene" of each taxonomical entity has been intensely searched, be it depression, anorexia or alcoholism.

But as the scientific investigation of reality progressed in the 20th century, in intimate contact with philosophy and pragmatically maintaining contact with the real world, it ended up, though not fully, overcoming the substantialist persective. (Scientific investigation at the highest level is today multidisciplinary, integrating different perspectives, including the philosophic. As simple example let me mention in USA the Santa Fe Institute, dedicated to the study of Complexity. An example of this work is S. Kauffman *Investigations. Complexity, Self-organization and New Laws for a General Biology.* Thus the epigenetic revolution –with the discovery that the "expression" of genes depends on a very complex system of relations among them, together with the rest of the non-genetic DNA and others factors, like a great quantity of cytoplasmic proteins, the cellular position with respect to the organism and the behavioral relation of this with the environment - has overcome the substantialist vision of genes, integrating them into the general living, ecologic system of which they are a part.

This is a changed ontological vision of reality, from the *substantialist* to a *dialectic/ communicational* model of the *complexity* of every system as life systems.[2] Life is not something within the organism (be it a functional-mechanical essence as in Cartesianism or be a subtle essence as in vitalism). In his book, *Emergence of Life: From Chemical Origins to Synthetic Biology* (p. 233), contemporary biologist Pier Luigi Luisi tells us that "Each living system is a complex of circular interactions with its environment, and this whole can be contemplated as a continuous flow of mutual and coherent changes, whose end is the maintenance of the balance of self-identity. And in his *The Phenomenon of Life: Toward a Philosophical Biology,* the great philosopher Hans Jonas, knowledgeable in scientific work, tells us: We must "consider organisms together with their environment, as a unique systems" (p. 70).

This "autopoietic" vision of life corresponds to the current ontological vision of the General Systems Theory, in which every local structural unity is a continuous dynamic process of differentiation of that structure with respect to the environmental field. As Niklas Luhmann informs us in this treatise about *Complexity and Modernity* (p. 35): "The relational theory (among substantive entities) has problems with identity and difference. The theory of systems always starts from the fact that identity is constituted through a difference with the environment". And this happens "in all complex systems where dynamic systems of formally similar functional organization emerge, although the concrete causal relations be very diverse", as the Nobel prize winner Prigogine maintains in *La estructura de lo complejo.* (Nicolis G. y Prigogine I., Alianza Ed., Madrid, 1994). Thus we see this only in the field of human life, but even in the field of consciousness. A. Gurwitsch already indicated this in his book of 1962, *El campo de la conciencia*. (Alianza, Madrid, 1979, p. 163), writing of "The structure (Gestalt) as a unity that is consolidated and separated from the field". Contemporary neurobiologists Edelman and Tononi move in the same direction, writing that "integration and differentiation are the fundamental properties of the conscious experience".[3]

This has given rise to an emergence ontology, in which entities are local products of the dynamics of generic processes of the field that create concrete structures, which in turn locally realize the field dynamics. The philosopher Whitehead already maintained this at the beginning to the 20th century in his book *Process and Reality* ("there are no things, only processes"), in accord with what western science was discovering at the turn of the century. Philosopher of science Mario Bunge articulated this position in his book, *Emergence*

and Convergence: Qualitative Novelty and the Unity of Knowledge. (University of Toronto, 2003).

This comprehension of essences as dynamic processes shaping the structural identity of entities is fundamental for general medicine and even more for psychiatry. Today allergic illnesses are not seen as an organic effect on the organism caused by allergens, but rather as a disharmony of the *informational relation* between molecules of the environment and the immune system of the organism. Disharmony that can cause the death of the organism – by an over-reaction of the immune system, as in anaphylactic shock or autoimmune diseases. However, the empiricist thrust of current classifications asserts that stress is a normal reaction of human life to the stressors. This is a reification of the "stressors" as facts or life circumstances that in themselves threaten the individual, ignoring the informational character of the situation, that is "shaped both by the circumstances, and by the *interpretation* of the experiential subject, conditioned by his personality, his biography, and by his personal ontology". "Objects of perception are the result of the contributions *both* of our theories *and* of the action of the external world over our sensory organs".[4] In contrast, "Empiricism at a epistemological level is usually associated with antirealism at an ontological ambit", as Wulff H., Pedersen S. A. and Rosenberg R. inform us in their *Introducción a la Filosofía de la Medicina* (Triacastela, Madrid, 2002, p. 44)

"Disease" is also a reification of the experience of "being ill", of a destructive way of being in the world in one's own life. The reification does not take account of the fact that life is a autopoietic, self-constructing process that is based on the appropriation and incorporation of environmental and personal resources. For this reason, the condition of somatic disease is essentially an "alteration", an "expropriation", a loss of one's inherence as an organism in the self-constructive, dynamic unity of life. But the harmony of this constructive process is based on the informational harmony that distinguishes and integrates the different molecular, cellular, and organic structures of the subsystems that integrate the coherent holistic unity of the organism. To live it requires being integrated into an ecologic system.

In the case of psychopathology, in becoming mentally ill, *alteration* becomes *alienation* and *expropriation* becomes *dis-appropriation*, as processes of the configuration behavior. I mentioned above phobias as clinical structures. The basic cause of every phobia is feeling threatened by the phobic object. This means that the subject –in the phobic situation– does not perceive the object as within his space of action, but perceives himself as within the reach of the threatening space of action of the object. This situation already implies the alienation of the active subject, transformed into a reified object by the disappropriation or loss of his own space of action and of the things that are in that space. The threat of destruction experienced by the personal subject is already completed, hence the anxiety. This accords with Zachar's point with respect to the "new scientific essentialism" of a passage from passivity to activity of natural structures, as indicated by Ellis. But Ellis' activism expressly referred to the "capacities that things have to actively respond to relevant circumstances". In the new horizon of the general systems theory, essential activism does not mean the capacity to react to circumstances, but rather an active process of differentiating each structure of the environment from the others, constituting one's own identity and clarifying the identity of the other. As Jonas writes, "The differentiation of sentience, with the central integration of its diversified data, furnishes the beginnings of a true world of objects; the active commerce with this world through the exercise of motility (in turn implying centralization, viz., of control) subjects it to the self-assertion of freedom, which thus answers on a higher plane to the basic necessity of the organism."

While this is the ontology of the contemporaneous science, product of critical ontological and epistemological investigation, it is not the operative ontology of everyday life. The phobia example shows us that the triggering stimulus is not the real object itself but rather what to the subject is the threatening suggested character of the object. Such character belongs to the ontology of a magical/animistic world, as in the way a phobia of scissors might represent stinging objects with an aim to attack the individual.

This brings me, finally, back to the beginning of my commentary, where I postulated the mental disease is a destruction or threat of destruction of the identity of a living entity, based on a dis-appropriate structure of behavior, on a misuse of the information provided in normal behavior. Regarding the latter, biologist/philosopher has maintained: "Perception and action, sensorium and motorium, are linked together as successfully emergent and mutually selecting patterns". (Francisco Varela in *The embodied Mind,* p. 163.) It is the integration of the sensibility and the motor function in the shaping of the perceived forms (*Gestalten),* magisterially analyzed by Viktor von Weizsaecker in his book *Der Gestaltkreis,* from 1939, and anthropologically described by Maurice Merleau-Ponty in *The structure of behavior* from 1942: "The properties of the object and the intentions of the subject (…) are not only intermingled, they also constitute a new totality".

What studies of infant psychology (beginning with Piaget) and evolutionary epistemology (as in the book *Mind from Matter?: An essay on evolutionary epistemology,* by Max Delbrück) show us is that:

1st.- Activity between the infant and its environment begins to generate a progressive distinction of *permanent forms* with their operative qualities. In the first months there are not permanent forms. As of 6 months, the child begins to perceive the *inter-sensory object,* which corresponds to what Aristotle called common sense (*Koinos Aisthesis).* With this there begins a specification of sensory things, with recognition of their operative qualities - *pragmatic objects* - along with the rise of an *active subject.* "Up to now there is a formal structuring of the child/environment pragmatic relation, based on the sensory motor organization". This period is analogous to the development of the sensory distinction in animals, between stimulus and sensation. "Animals perceive Gestalten (…) men Gestalten and things". Gemelli A., *Introduccion a la psicologia* Luis Miracle, Barcelona, p. 213.

2nd.- As of the second year, real human, cognitive development occurs, based on sensory experience. Phenomenalism gives way to perception of relational structures. The object is separated from

the pragmatic context and acquires permanent identity in the face changing circumstances. The child begins to designate things with names, beginning denotative language. He recognizes things as independent of his activity with them. The self is recognized as involved in operative matrices with things, including causal relationships. These relations with things do not follow the perception of things but are constitutive of the things themselves. "What we call things only exist in knots of relations," as Zubiri tells us.[5] This is a basic onotology that is pragmatic, pre-linguistic, and pre-reflectively interpretative of the entities of the world.

The *pragmatic interaction* constructs both the identitarian permanence of the object and the subject of perception. Another thing is that afterwards the behavior *seems* to take its origin only from the perception of objects. As Hans Jonas indicates in his indicated book of *Philosophical Biology* (pp. 48/9): "The apparent constancy of the object of perception in the face of how it is handled constitutes an inversion of the real genetic relations". It is this pragmatic genesis of the natural, pre-verbal, pre-conceptual, pre-reflexive object that gives the perceived the character of being something prior to perception, and to the perceived thing the formal character of "being beyond" the subject.

This stage –from 12 to 18 months– constitutes the moment of becoming human, of the apparition of a pre-linguistic, praxic world, a pre-verbal and pre-conceptual ontology, that will allow the further possibility of a world whose *logos* becomes expressed, shaped as verbal expression and a world of thought. It is the moment of constitution of what we have been accustomed to call transcendence since the pre-Socratics. It is not the exercise of a faculty of the human spirit of going beyond (*metà*) the physical things, but the construction of the cognitive duality: the perceived and the act of perception of the perceiver! This pragmatic construction of the world, between the praxis of the child and the power of consistent and persistent structures of the environment over the child, is a co-organization of the perceptual world. In phenomenology, primary consciousness is "*I can,"* not *I am.*

This transcendence of a natural ontology, constitutive both of the things of the world and of my own identity as acting on those things, is what is initially lost in schizophrenia, described by Blankenburg as the "loss of the natural evidence," as well as at the origin of other symptoms such as strange behavior and delusional thinking.

The permanence of the objects of this pragmatic ontology is what enables the denomination (*denotation)* and the generation of an idea of the thing. As Gehlen informs us in his anthropology (*El hombre,* 1974, p. 186), "The constancy and the transposability (…) are the conditions for man to be able to see things." Cognitive deteriorations are manifestations of the loss of the formal capacities of the brain for distinction and synthesis, that generate the ontology of the world.

3rd.- Between the 18 and 24 months the mental sphere is constituted as an articulated and spoken world. In this symbolic domain semantic structures are developed that represent material things that are not sensorially present. Things can be presented as images and concepts, and discussed in words. Initially the child does not differentiate concrete from imaginary reality, nor designate the thing by its name, as Zachar himself indicates, and which we see in many psychopathologic structures

Starting with this period formal structures of thought and language are developed in progressive levels of maturation up to adolescence. These different formal levels of thought imply different mentalities, with different logical forms, that form different mentalities and life worlds at each maturational stage. In a simplified scheme: in the 1st) stage of infancy the mentality is magical and the world is physiognomic-animist. In the 2nd) stage the mentality is mythic and the world in dogmatic/ideological. In the 3rd stage and into adolescence, there appears a critical mentality, questioning dogmatic beliefs, with the possibility of developing one's own standards and participating in the structure of one's life. This is the period of developing one's own personal identity: at first immaturely, grandiose pretentions of an ideal world, and then maturely, with a more realistic sense of the world and one's own capability to develop realistic goals.

Psychotic psychopathology develops from disturbances of the global brain networks responsible for shaping the ontological forms of the basic, pragmatic world. These disturbances of the formal fundamental structures of the world and of oneself are responsible for serious psychotic illnesses such as schizophrenia, non-schizophrenic psychoses, and the dementias. They are disturbances of the basic ontology of the individual, originating in its pre-reflexive and pre-theoretical behavior.

The psychopathologic structures of the **neuroses** or *affective disorders* are structures that *alter* the person and his behavior, for their "affecting sense" of the appropriative realization of the subject life. They are perturbations of the "ways of feeling" affectively the "modal senses" of the things and circumstances of the given world have for the realization of the own life of that person. *Senses* not only conditioned, but *determined* by the "type of conceptual world" the person has, depending

The Mind-independent World, Metaphysical Heuristics, The Nature of Psychiatric Disorder, and the Relationship between Psychiatric Classification and Psychopathology: Response to the Commentaries.

Peter Zachar

Introduction

I would like the thank Jim Phillips for devoting an issue of the *AAPP Bulletin* to *A Metaphysics of Psychopathology* and thank him also for working so hard to both assemble and edit the commentaries.

Writing the book was an all-consuming project for three years. It is a pleasure to be able to return to it and explain myself, elaborate, and rethink some of what I wrote.

I have grouped the commentaries in clusters so that my responses can approximate a coherent progression from beginning to end. Prior to each cluster, I will make some preliminary remarks and then respond to each commentary separately. My individual responses were written with the assumption that readers would first review the preliminary remarks.

Empiricism and the Mind-independent World (Rego, Thornton, Cooper)

According to basic realism, the world/universe exists independent of our knowledge of it, it existed before humans came to be, and would continue to exist whether or not we were still around. It does not exist because we perceive it.

It would not be useful to doubt basic realism any more than it would be useful for anyone living to doubt that there were people and societies before us and there will be people and societies after we die.

Empiricism is often understood as asserting that human knowledge is limited to what is available to us through experience. That does not mean, however, that what we know is limited by immediate experience. For instance, we make inferences that go beyond immediate experience when we accept the premise of *object permanence:* that things continue to exist even when we are not sensing them. David Hume thought of this as an automatic and habitual inference, Jean Piaget a cognitive achievement. I agree with each of them.

The empiricist tradition's emphasis on experience was a response to a deep mistrust of abstract concepts, especially metaphysical concepts. John Locke, in particular, was apprehensive about our propensity to adopt an attitude of certainty about abstract doctrines. For example, in Locke's lifetime there were violent conflicts over abstract concepts such as papal infallibility and the divine right of kings. An important goal of Locke's *Essay* was to regiment our speculative abstractions by asking that their links with experience be better mapped out.

Typically, Locke's project of linking abstract concepts with something in sensory experience is narrowly interpreted as a doctrine regarding the experiential origins of mental content. An important metaphysical claim that is often attached to Lockean ideas about content is that we cannot get beyond all experience to know things as they are in-themselves. This raises an important problem. If human understanding is bounded by the limits of experience, what justifies us in accepting basic realism and the notion of a mind-independent world?

Most people who think about these things, including myself, believe that it is a mistake, even epistemologically irresponsible, to reject the notion of a mind-independent world. I set out to examine this problem with the eyes of a pragmatist. In adopting a pragmatist perspective, one asks: what is important about the concept of a mind-independent world, or what work does that concept do for us. More specifically, how does it helps us to adapt (survive or thrive).

What is important about the concept of a mind-independent world is that it means things can be very different than we believe, or want them to be, and that we might be mistaken. In the book, two norms I articulated with respect to this insight are: *Do not fool others* and *do not fool yourself*. Adherence to these norms makes us more likely to notice and admit mistakes, and in the long run correcting mistakes is adaptive, no matter what your goals.

These important insights, that one can have conviction yet be mistaken and that things do not conform to our wishes, can be fully formulated with the resources that experience provides. We do not need to get beyond experience to grasp them. Understanding this is a cognitive achievement, and "the mind-independent world" is a handy everyday metaphysical framework for explaining it.

Taking a more Humean view, we can say that experience is ordered in many ways, and some of those ways we name, "subjective," others "objective," some "fiction," others "fact." For Hume, the "external world" is an ordering of experience that is distinct from those orderings of experience that we identify with imagination and preference. In his view, these distinct orderings have a different feel to them. The same is true for our beliefs about abstract concepts versus our beliefs about the particulars of daily life. The Lockean worry discussed earlier refers to the mistake of adopting about abstract concepts a feeling of certainty that is only appropriate to the particulars of daily life.

One potential criticism of this view is that it twists things around by using experience to explain the idea of the mind-independent world rather than using the mind-independent world to explain our experience. Does an experience-centered approach diminish the very notion of a mind-independent world by making it a feature of human psychology? No. Viewing an objective versus subjective distinction as lying within but not beyond experience does not diminish the notion of mind-independence any more than abandoning the idea of a vital force diminished the specialness of life and death. The significance of each of these concepts remains intact. I will further address the "psychologism" charge in my response to Mark Rego.

What do such philosophical considerations have to do with psychiatric disorders? Quite a bit, actually. For instance we can ask if anyone in the 12th century developed PTSD even though that concept was not introduced until 1980. Are psychiatric disorders what George Graham calls "act of classification independent." My answer is: Sort of– it all depends on how you look at it.

Locke is illuminating on the topic of mind-independence, particularly with respect to the concepts we have for naming the ways that things and events are ordered or patterned. He called these patterns modes, and contrasted them with self-subsisting entities. Examples of modes include justice, beauty, and murder.

Consider murder. Is murder something that is out there in the world independent of whether we know about it? Sort of. Let us assume that a group of forensic scientists discover that a well-known historical figure did not die of a natural illness as previously believed, but was poisoned. A murder occurred though even we did not know about it. Consider, however, the following distinctions - infanticide, matricide, patricide, suicide, manslaughter, euthanasia, animal slaughter, insecticide, and herbicide. People would disagree about whether these are all types of murder. For instance, is euthanasia murder? My dog has no concept for any of these types of killing, nor for murder itself.

These concepts are what Locke called the workmanship of the human understanding. They refer to actual phenomena that occur whether or not we want them to and so are not constituted by our naming practices, but the distinctions are also made by us – often for particular purposes. Very importantly, "workmanship" entails that some aspects of phenomena are included in our concepts, and others aspects elude them.

Another way of saying this is that abstract concepts are inadequate to the rich particularity of experience in one way or another. Things have histories and they are related to other things in

many particular ways. No concept or classifications can capture all that particularity. This inherent limitation of concepts and classifications is the basic insight of *nominalism*.

Psychiatric disorders work the same way, to varying degrees. Psychopathological phenomena occur whether or not we want them to, but concepts such as hysteria and schizophrenia are the divisions of human understanding, as is "psychiatric disorder" itself. They are patterns that we happen to recognize and name, thus echoing Locke's notion of workmanship. The reason for calling this "workmanship" is that the patterns we name are (hopefully) systematic regularities, but also interest-relevant samples of the many patterns that are there.

To what patterning of phenomena does hysteria refer? Interestingly, that has changed over time. In the not too distant past many of these cases we currently name histrionic, borderline, narcissistic, PTSD, somatic symptom disorder, and conversion disorder would have been included in the extension of hysteria. At one time hysteria was considered to be obviously real, but few hold that view now.

The construct of schizophrenia is also in dispute. Some see schizophrenia as a valid medical disorder; others see it as a reified category that distorts of understanding of a broad class of psychiatric phenomena.

Are hysteria and schizophrenia real? Did they exist before we noticed them? The phenomena occur whether we want them to and so are real in one sense. The critics of these classifications, however, claim they do not live up to our evolving norms for valid psychiatric disorders. In the critics' view, what past thinkers meant by hysteria and schizophrenia misinterpreted and distorted the phenomena, so they are not real in another sense.

Mark Rego

Mark Rego and I agree on our endemic epistemological fallibility - what he refers to as the disconnect between our understanding of the natural world and the natural world as it exists. We also agree that our knowledge is limited, partial, and often biased. Where we part ways seems to be about the degree to which our fallibility needs to be metaphysically augmented.

Rego's concern is that pragmatist scruples do not offer an adequate explanation of our limitations. For instance, consider the claim that obsessive-compulsive disorder can be successfully treated by exposure-habituation theory. How are we to make sense of that truth claim? Is the claim true because we can act on it if properly trained (pragmatic theory of truth)? Is it true because it is consistent with others things we know about human behavior, cognition, and neurophysiology (coherence theory of truth)? What I read Rego saying is that the truth about treatment with exposure-habituation is out there in the world – in the metaphysical nature of OCD.

For Rego, pragmatic considerations and coherence are factors in deciding what is true, or guides to truth, but not adequate theories about the nature of truth. Many philosophers would say that the nature of truth is represented by the correspondence theory, i.e., a statement is true if it corresponds to reality, or alternatively – is true if it corresponds with the facts.

My concern about this formulation is that the pragmatic theory and the coherence theory were developed to address flaws with the correspondence theory, not as competitor universal theories about the nature of truth. Empiricists and pragmatists– as nominalists – are suspicious of considering truth as correspondence with the facts as a universal – as a property that is fully present in all true statements. They might still utilize handy epistemological notions like "confirm," "mistake," and "correct," but not invariably define them in terms of correspondence with the facts.

One flaw of the correspondence theory relates to Rego's notion of the disconnect between our understanding of the natural world and the natural world as it exists. Given such a disconnect, how can you ever know that your concepts correspond to the world as it exists in itself? Is there only one way to correspond? How would you check that the correspondence is there?

In addition, how do we know if what our statement corresponds to is indeed a fact? It would be circular to claim that a fact claim is true if it corresponds to the facts. One way to avoid circularity is to allow pragmatic tests and considerations of coherence to inform what it means to be a fact. If so, the correspondence theory depends, in part, on the pragmatic and coherence theories.

For Karl Popper, the correspondence theory of truth was a useful regulative ideal, but did not have anything to do with how we decide what assertions to accept. He considered correspondence to be a type of verificationism, which he rejected in favor of falsification. Unlike Popper, I believe that that for some kinds of assertions, checking for correspondence with the facts can be an epistemic guide. For cats on mats and the shapes of planets, correspondence is something we know how to check, and do, but those kinds of assertions form only a small part of what accept as true.

Arthur Fine defines the natural ontological attitude as follows. When we accept the everyday facts of our life and the claims of abstract science to be true, we accept them to be true in the same way (despite different levels of confidence in what we accept). According to Fine, realist arguments supplement the natural ontological attitude in one way (i.e., metaphysically construed correspondence with reality), and pragmatists and empiricists do so in another. For example, Fine says some pragmatists treat the pragmatic theory of truth as a universal theory of truth.

Hopefully I have made clear that my pragmatism is not of that sort. I will say a little more on this topic in my response to Tim Thornton and refer back to it again when I address Jim Phillips.

Let me also address Rego's post-apocalyptic rocket launch. A rocket was designed by NASA to automatically launch on a specific day and time, but before that day arrived, all humans on earth perished. Despite that unfortunate occurrence, the NASA computers would still launch the rocket into space. The reason the launch would be successful, says Rego, is because the knowledge used to automatize the launch was representing an objective, mind-independent truth about the world. And that is what we should seek to know, even if we fall short.

I agree with the sentiment, but not the implied metaphysical augmentation. Rego declares that my claim that the resources of experience are adequate for making metaphysical distinctions excludes something important. It excludes what is beyond experience, the mind-independent world, or objective reality. In his view we need a concept of the

external world - out there, and independent to adequately explain our limitations.

One of the best responses to this challenge can be found in Tim Thornton's commentary. He uses Wittgenstein's claim that we fail pay attention to the details of language and practice because we do not believe that they are relevant to some of the questions we are asking – such as why we utilize the metaphysical distinctions that we do. Included in "we" are those who believe that only something behind or beyond the details of language and practice are needed to explain metaphysical distinctions. The problem is that a "reality" that lies outside of experience cannot explain the distinctions we actually make internal to experience. According to Tim, not only are explanations for our distinctions to be found in the details of language and practice, those are the only resources any of us have. For instance, none of the information or technology that was used to program the rocket was beyond language and practice.

As I noted in the book, qua pragmatist, I purposely chose to use William James' concept of "experience" rather than Richard Rorty's term "language," but I do not believe that the difference matters here.

Rather than repeating Tim's examples which people can read for themselves let me propose another analogy for Rego's claim, specifically, one of Rene Descartes' arguments for the existence of God. To simplify greatly, according to Descartes there must be at least as much reality in the cause as in the effect. For example, he says that the energy in a hot object can only be produced by something that has at least as much energy itself. Analogously with respect to ideas, he says the degree of reality represented in an idea must be produced by something that has at least as much reality itself.

In Descartes' view, our ideas about material objects, animals, and other people could have been produced solely within our minds, but this is not the case for our idea of God. The reality in the idea of God, and his attributes such as omnipotent, omniscient, perfect and infinite could not be produced by our imperfect and finite human minds. The only thing with the required degree of reality is God. Therefore, our idea of God, claims Descartes, must be an innate idea placed in our minds by God.

This argument is not the least bit convincing. It is well within our capacities to grasp a concept such as degrees of power and imaginatively extend this to a notion of omnipotence. An actual all-powerful being is not needed to explain having the concept of omnipotence. The same for omniscience, perfection, and infiniteness.

Analogously, we do not need to know something beyond all experience to formulate concepts such as mind-independence and reality. Both of them are important parts of experience. A person who assumes that only something totally outside of experience can explain mind-independence and reality would see the specter of idealism in the empiricist approach, but that assumption inflates mind-independence into something unnecessarily "metaphysical."

Minimalist and Deflationary Metaphysics (Thornton, Cooper)

Both Tim Thornton and Rachel Cooper are sympathetic to my attempt to formulate a more metaphysically minimalist approach to psychopathology, but each also argues that I fall short and make unnecessary metaphysical assertions. I begin with two preliminary comments.

First, in writing the book I began with the minimalist metaphysical commitments of an empiricist and was attracted to deflationary accounts. I then tried to expound on those from a specific kind of pragmatist framework. In the book, I called it scientifically-inspired pragmatism in contrast to the neo-pragmatism of Richard Rorty. In retrospect, I could have also called it Anglo-pragmatism (encompassing Scotland (Hume) and Ireland (Berkeley) of course). Pragmatism in my framework is a variation on the empiricism of Locke and Hume that was articulated after the publication of Charles Darwin's *Origin of Species*. This variation was formulated by some Americans in the late 19th century – including William James - who were at just the right age to quickly accept evolution by natural selection without preformed opinions getting in the way.

It may be that in looking back to James and Locke, I end up working with metaphysical assumptions that subsequent generations of philosophers have learned should be rejected, such as the subject versus object split or the representational theory of perception. This might be a valid point. I will try to explain my interest in metaphysical issues more specifically in my response to Rachel.

Second, an important consideration in writing the book is that psychologists, psychiatrists, and other mental health professionals freely use metaphysically elaborate concepts. In introducing more minimalist concepts, it is important to contrast them with the commonly used elaborate concepts. For example, in chapter 7, I proposed a minimalist account of the objective as a word we use to flag things that some people may wish were not the case, but nevertheless are the case. I contrasted that with The Objective as that which lies outside experience.

Tim questions me for comparing a partial and minimal notion with an elaborate metaphysical notion that is disallowed in my framework. There is a deeper problem about "the reality that lies beyond experience" here that I will address in my response to Tim. For now, let me say that part of what I was doing was contrasting my proposed notion of the objective as resistance to what we prefer with what I assumed is the more usual and elaborate notion of The Objective that most people vaguely adopt. The purpose of making that comparison was to show readers that there is an alternative to the more usual and elaborate notion.

Tim Thornton

Tim argues that mixing the epistemic guides of the pragmatic and the coherence theories with the metaphysical correspondence theory of truth is shotgun wedding of what is dependent on and independent of human judgement. To some extent I addressed this in my commentary on Rego with respect to epistemic guides versus universal metaphysical definitions, but let me say more here.

Although it is important to recognize how our psychological make up plays a role in what we believe (i.e., naturalized epistemology), it is also important to not conclude that what "is true" is only a function of human psychology. I am not convinced, however, that the pragmatist and coherentist perspectives are only dependent on human judgment.

For example, pragmatists believe that the claim "it is raining outside," partly means "if you go outside you will get wet." When you go outside to run that test to decide if that claim is true, whether or not you get wet is not dependent on human judgement. Consequences have a degree of independence. The same for coherence. If a reconstruction of evolutionary history using the fossil record coheres with an independent reconstruction using DNA, that is more than dependence on human judgement.

Next, I would like to try to better explain myself on an issue raised by both Tim and Rachel. Specifically, my claim that what Arthur Conan Doyle ate and drank on a particular day in 1903 was once a matter of fact, but is now not a fact because the information is not accessible to us. Tim wonders if this commits me to an anti-realist view of the past. He and Rachel both ask, did Doyle or did Doyle not eat breakfast on that day. If the answer is either true or false it would seem to be a matter of fact. And therefore real.

I doubt that the King Arthur of legend is a real historical figure, but the Saxons did invade Britannia. More to the point, I agree that on logical grounds alone, Doyle did or did not eat breakfast. Yet on logical grounds alone, Tony Soprano was or was not shot in the scene that would have followed the conclusion of the final episode of *The Sopranos*. This truth of logic, however, does not commit anyone to realism about the Soprano-verse.

Furthermore, I did not ask *whether* Doyle had breakfast, I asked *what* he ate and drank for breakfast. I introduced the question about what Doyle ate and drank because I was working with my notion of what we mean when we say something is a fact. When we say something is a fact we effectively mean: *you are obligated to accept this assertion no matter what you to want be the case*. In part, I was working with a concept of information used by some physicists. For example, if a star 100 light years away was currently exploding, we could not know about that explosion for 100 years. Whatever causal factors are operating in our area of space time, that explosion is not one of them. In addition, anything that is more than 15 billion light years away from us is something whose existence no one living will ever know about. It is not possible to make factual assertions about that which we can have no information.

If we cannot access any information about what Doyle ate on that day, we cannot make factual assertions about that either. For all practical purposes, it is not a possible fact for us. That is what I meant.

This was also part of the thinking behind my criticism of Jerry Wakefield's harmful dysfunction model. Given that we lack information about the selection pressures operating during human evolution, our menus of natural psychological functions are only speculative, and the same for failures of those natural functions. We therefore cannot check to see if there is a factual dysfunction to demarcate disorders from states of normality. That demarcation is done using other resources that are available to us in experience (i.e., the perception of particular kinds of impairment)

My final two responses to Tim's commentary also serve as a transition to my responses to Rachel Cooper. First, Tim observes that I set out to write about how we actually make important metaphysical distinctions on the basis of experience alone, but that I also have a tendency to talk about what is beyond experience.

For instance, Tim suggests that, in part, I harbor an idea about reality as something that exists independent of experience and thereby beyond experience. Furthermore, it is something that we cannot access because we are trapped in our heads or in our language. I appreciate Tim's calling my attention to the difference between "mind-independence" and "beyond experience." And it is correct that in one of the examples he discusses taken from chapter 1, I talk about what lies outside our experience, i.e., reality is one of the names we give for what lies outside the limits of our current experience.

I did not, however, mean what lies outside the limits of all possible experience. It was just a way of saying that there is more to the world than we know, but we accept that based on experience. We have good reasons for accepting that matter-energy is both particle and wave, but that information was beyond human experience until recently, even though matter-energy was particle and wave before humans ever evolved. We can assume that in the future scientists will have evidence for accepting things about the world that are beyond us now. It is a way of seeing that part of what we mean by reality is that some things are the case independent of what we happen to believe and know.

Second, Tim notes that despite my claims to the contrary, it is not clear that I in fact succeed in trying to stay within the limits of human experience without becoming some kind of an idealist. Tim's worry with respect to my empiricism would seem to be that empiricists advocate for a gulf between the subject and the object, and thus are vulnerable to being idealists about what we know.

It is a fair and good point to make. From a pragmatist standpoint, however, I would not absolutely disallow making a distinction between subject versus object, inside versus outside my body, or in my head versus in the world. There are a lot cases in which these can be informative distinctions to make.

Tim suggests that a resort to direct realism could solve the problem posed by an implicit idealism. I cannot confidently respond because I am only minimally familiar with direct realism, but understand its attractiveness from a practical standpoint – beautifully expressed by Hume in his characteristically optimistic and open-minded conclusion to book 1 of the *Treatise*:

Most fortunately it happens, that since reason is incapable of dispelling these clouds, nature herself suffices to that purpose, and cures me of this philosophical melancholy and delirium, either by relaxing this bent of mind, or by some avocation, and lively impression of my senses, which obliterate all these chimeras. I dine, I play a game of back-gammon, I converse, and am merry with my friends; and when after three or four hours' amusement, I would return to these speculations, they appear so cold, and strained, and ridiculous, that I cannot find in my heart to enter into them any farther... Here then I find myself absolutely and necessarily determined to live, and talk, and act like other people in the common affairs of life.

Not only do we adopt common sense realism about the activities of daily life, we also do so about the discoveries of science when we adopt the natural ontological attitude. My worry though, is that this is a few steps away from being a very unphilosophical attitude – and least from the standpoint of modern philosophy. Hume also wrote, some-

what critically, about those honest gentlemen whose thoughts extend very little beyond their domestic affairs and common recreations – and such a direct realism seems just as unpalatable as idealism. I would argue that a more philosophical attitude is anchored by the distinction between primary and secondary qualities or the broadly Kantian metaphysics of the structure of experience.

In writing the book I emphasized several general guidelines that I consider to be not readily compatible with idealism. These include the belief that there have been people and societies who lived before us and there will be people and societies after we die; the decree that we should conceptualize the world the way it is, not how we want it to be; and the judgment that experimenting, trying something out, and putting our beliefs to the test gets us out of our heads and into the world.

Rachel Cooper

Like Tim Thornton, Rachel Cooper calls me to task for aspiring to a minimalist metaphysical account, but then promulgating a host of metaphysical commitments. These would include non-essentialism, pragmatic and coherence views on truth, nominalism, and radical empiricism. She and I largely agree on many substantive issues regarding psychiatric classification and psychopathology, and according to her nothing that we agree on depends on the metaphysical commitments we make. In her view, this makes these commitments optional.

In this respect, I plead guilty as charged and see how this could be considered problematic. Yet, there are also reasons for acknowledging metaphysical commitments and for developing them further. Let me explain.

My attitude about metaphysics partly has to do with the perceived failure on the part of the mid-20th century logical positivists to banish metaphysics to the realm of the meaningless. As Karl Popper noted, metaphysical commitments might not be scientifically based, but they are not meaningless. For him metaphysical status was a matter degree, and many important scientific propositions, such as "matter is composed of atoms," begin life metaphysically. Imre Lakatos talked about research programs (largely, paradigms) being guided by metaphysical assumptions, including hard cores/negative heuristics that are immune from being tested and more flexible positive heuristics that are tested. With respect to psychopathology, folk metaphysical assumptions, scientific metaphysical assumptions, and philosophical metaphysical assumptions all play a guiding role. I do not believe that Rachel and I would agree on substantive issues in psychiatric classification and psychopathology unless we shared an implicit metaphysics, however minimal.

As I wrote in the book – and agree with Rachel - metaphysical concepts are often obscure, all the more so because they tend to be defined in terms of other obscure abstractions. In order to navigate through the fog of metaphysics, it is useful to have some accessible anchor points., i.e., respected authorities around which you develop a philosophical identity. In combination with philosophical temperaments, chance factors related to your professors' expertise what we were exposed to in school and play a role in the development of our philosophical identities and habitual commitments.

Rachel mentions John Dupre's promiscuous realism was an anchor point for her. For me at various times that would have been Richard Rorty, Ian Hacking, Nelson Goodman, William James, and earlier my former professor Mark Johnson and his colleague George Lakoff. Johnson and Lakoff are particularly good about showing how some metaphysical commitments are readily apparent in language, yet not seen as metaphysical.

My attitude about metaphysical commitments partly has to do with my training in counseling and psychotherapy as well. When I was in training there was a lot of thought being put into theoretical orientations and the value of eclecticism. Many came to believe that adopting a rigorous eclecticism would result in having a fragmented perspective on clients. It would be better, they believed, to commit to mastering a broad theoretical model and thereby achieve a coherent and comprehensive perspective on clients. This also assumed a willingness to accommodate the theory to new approaches that are shown to work. For instance an object relations theorist would have to conceptually accommodate to the use of medication and treatments such as exposure-habituation.

For similar reasons, I believe a consistent empiricist-nominalist-pragmatist perspective is worth pursuing – especially for one who has a temperamental inclination to metaphysical minimalism. The goal is to develop a deeper, more comprehensive, and subtler perspective than would ensue from a shopping cart approach to metaphysical heuristics. If looking back to James and Locke makes me vulnerable to using outdated doctrines such as a subject versus object dichotomy, it is important to try to accommodate my perspective to newer frames of thought.

On the topic of my metaphysical commitments to non-essentialism, I will discuss that in my response Jim Phillips and Jeff Bedrick in the following section.

Am I a Closest Essentialist?
(Phillips, Bedrick)

I am addressing Jim Phillips and Jeff Bedrick together because they adopt interestingly distinct attitudes toward my non-essentialism. According to Jim, I am arguing against a Platonic strawman and according to Jeff I am a closet essentialist. These are serious charges and both worth pondering. I am sympathetic to Jim's concerns because essentialism, like all metaphysical abstractions, can be obscure. If essentialism is expected, it can be readily seen even when it isn't there. I am also sympathetic to Jeff's concerns because we are all prone to essentialist thinking, and getting beyond it on an intuitive level is a struggle. That I might not always do so is a distinct possibility.

Before proceeding let me note that both of them use a similar argument, i.e., they declare that my statements "the truth of any claim is an inference supported by evidence" and "psychiatric disorders involve a decline-in-functioning" are general definitions in the spirit of essentialism. In response, let me say that offering a definition does not commit one to metaphysical essentialism. Unless one specifically proposes necessary and sufficient properties in a definition, it does not commit one to essentialism about meaning either.

Jim Phillips

Although Jim fears that I am focusing my efforts on a Platonic strawman, he does not believe that I am, on the whole,

being quixotic and tilting at essentialist windmills. He views himself as a non-essentialist in the Wittgenstein mode.

Wittgenstein comes up a lot for me, from "sounds like Wittgenstein" and "why didn't you mention Wittgenstein" to "your failure to mention Wittgenstein is the major flaw of the book." The reason I do not mention Wittgenstein is I am not familiar enough with him to do so. Of course Wittgenstein's influence is widespread and his ideas are unavoidable, but his purposes are a quite opaque to me so I pass over him in silence.

Attributing metaphysical beliefs to others is a risky business, especially when those beliefs can be used as terms of insult, like essentialism sometimes is. For articulate and able defenders of essentialism such as Brian Ellis, I was willing to make an attribution, but otherwise, I tried to talk about essentialist thinking as a tendency about which we should all be worried.

As for Plato, I use him as contrast to nominalism because of his advocacy for universals. Advocacy for universals is still common in philosophy. Focusing on universals, I referred to Socrates' claim in *Meno* that just as all bees must share a single nature in common as bees, so all the different virtues must share something in common as virtues. What made this claim about virtues persuasive at the time was the comparison with bees. For many nominalists, what decisively undermined it was Darwin's view of species as populations of individuals that vary.

Another potential strawman Jim addresses is the creationist belief in "Truth" as a contrast for the scientific empiricist's belief that truth claims are inferences supported by evidence. Jim writes that creationism is a straw man, but it would be harder for him to assert this if he lived and worked in the deep south as I do.

As part of the broader project of the book that Tim Thornton mentioned, I was trying to make sense of a mutual epistemological rift between what some call "the reality-based community" versus "the faith-based community or between those who accept facts versus those who use terms such as "alternative facts." Interestingly, both groups readily claim that rationality, critical thinking, and informed opinion describe *their* approach to belief formation, and distinguishes them from those on the other side. Academically-inclined intellectuals who identify with the reality-based community have a tendency to make those who prefer the faith-based community into ignorant cartoon figures, but that is harder to do when you live and work around them. When either side is not reduced to a cultural stereotype, this epistemological rift becomes very philosophically significant.

What I suggested later in the book is that we won't make progress on this clash unless we accept that very few of our beliefs are based on an individual assessment of the evidence. Much of what we believe is based on the testimony of "experts" who are recognized as authorities in one or more communities with which we identify.

To some extent what I said about truth in chapter 1 was signaling my attraction to deflationary accounts. Many philosophers hold that truth is a property of propositions, but deflationists deny that truth is a property. To believe that the proposition "Snow is white" is true, does require believing that this proposition has the property of *being true*. If by properties we mean "the way things are," a quality called trueness is not the way anything is. This was reflected in my nominalist claim that true propositions do not share a universal property called truth.

Such deflationary considerations motivated my assertion that in making truth claims we are not detecting the presence of the property of truth. When I said that to make a truth claim is to make an inference supported by evidence, my point was that scientifically-inclined thinkers do not accept something like the theory of evolution by means of natural selection because it possesses the property of being true, they accept it based on evidence. One problem with saying that valid truth claims are based on the evidence is that it does not address who decides what counts as evidence, or how, with evidence, in hand we make inferences to abstract and general truth claims.

In in addition to deflationism, another inspiration for this material in the book was being informed by a close acquaintance that all of our rights come from God, and that this is a *fact* and *the Truth*. It seemed to me that the word truth here was being used in a foot-stomping and desk-thumping way: "Our rights come for God, *truly*!" My question at the time would have been what is your evidence for this claim or what do you mean by fact?

In describing scientific empiricism as a contrast to the epistemological view of my acquaintance, it might have been better to say that the empiricists base their beliefs on a consideration of evidence and a systematic attempt put beliefs to the test to see if they may be faulty. This eye on progress should be balanced with commitments – which play a useful role by fortifying us to not immediately concede to every criticism. Furthermore, considerations of coherence and consistency are always important in deciding what to accept. To accept something, ideally, we balance the different considerations just mentioned, and select from the best alternatives. Also, later in the book I would have said that they expect that a similar check and test process influenced the beliefs of the authorities upon whom they rely.

With respect to psychiatry and psychology, in many cases we accept that things are true, often with conviction, but no single person can comprehensively survey the evidence and reasons supporting truth claims about the history of psychiatry, DSM categories, the causes of psychiatric disorders, and what works in psychotherapy and psychopharmacology. Even in our areas of expertise, we are dilettantes in many respects. My worry is that believing that truth is a real property out there in the world amplifies a disposition to believe with conviction. The problem with conviction is that, in practice, it rules out the possibility of being mistaken.

I am fully sympathetic with Jim's argument that the distinction between coherence and correspondence to the reality depends on how language is used, as can be seen in my responses to Mark Rego and Tim Thornton.

Jeff Bedrick

Jeff begins by wondering if combining pragmatism with nominalism is a way of preserving psychopathology, psychiatry, and psychology as scientific disciplines. I don't believe they need preserving as scientific disciplines. It would be more correct to say that pragmatism and nominalism offer a way to

be scientific without leaning on certain metaphysical illusions.

Jeff's commentary also obligates me to tackle the thorny task of defining terms with precision. It is important to try to define terms clearly, but in those cases where meanings are somewhat open, seeking a precise and complete definition is like a working puzzle that has no final solution. Abstract concepts such as essence, impairment, and psychiatric disorder are potentially problematic in this way. Nevertheless, some clarification would help.

Jeff's main claim is that, for me, decline-in-functioning serves as an essential feature of psychiatric disorder. The term essential feature is often used as a synonym for "necessary." Do I believe that decline-in-functioning is necessary for psychiatric disorder? No. Decline-in-functioning does not seem to be a necessary property of personality disorders, ADHD, and some learning and communication disorders. The autistic spectrum is more variable, but does not always involve a decline.

Although I do not propose that decline-in-functioning is a universal feature of psychiatric disorder, Jeff is on to something. A more difficult question for me would focus on impairment because decline-in-functioning is a feature of some impairments. Do I believe that impairment is necessary for psychiatric disorder? In the book I argued that, because we lack information about natural psychological functions and dysfunctions, we use either actual or potential impairment as a dysfunction indicator.

Does it make sense to say that someone could have a psychiatric disorder, but not be impaired in any way? Some thinkers associated with the World Health Organization (WHO) believe that it does. According to them, disorder and impairment are separable. What they seem to mean, however, is one can have a psychiatric disorder, but still function adaptively. In addition, they suggest that the relationship between the severity of a disorder and the degree of impairment is moderated by the environment, and by the resources and vulnerabilities of the person. So impairment is not an inherent feature of disorders.

The problem with the WHO goal of separating disorder from impairment is that some symptoms are considered symptoms because they are inherently impairing, such as psychomotor retardation. Others such as grandiosity are not *inherently* impairing, but they are symptoms because they can be impairing. At the very least, a psychiatric symptom cluster should make it harder to function as usual – which is impairment. Clinically significant suffering is also impairing to the extent that it can be harder to function with it than without it.

So it would seem that I do advocate for some necessity about impairment with respect to psychiatric disorder. Let me qualify this in two ways.

First, the "necessity" of impairment is established by the goals and purposes of psychiatry. The World Health Organization Disability Assessment Schedule (WHODAS) conceptualizes impairment dimensionally, suggesting that there may be a fuzzy boundary region between impaired and not impaired. Impairment not is a universal property equally present in all psychiatric disorders; rather it is a collection of ways we fail to live up to a variety of norms such as "you should be able to start a conversation" or "you should be able to join in community activities."

If impairment is a necessary feature of disorders, it is partly because it is an external entry rule for something being considered a disorder. A condition that did not involve actual or potential impairment would not be deserving of treatment and not considered to be a psychiatric disorder. This gives a stipulative aspect to the "necessity" of impairment. For instance, there is some debate about whether the successful psychopath or the successful narcissist have personality disorders. The problem is that on the surface, some cases of psychopathy and narcissism do not meet the entry rules for being disorders.

Second, I would not call impairment a metaphysical essence. Impairment is a feature of psychiatric disorders, not a cause. So impairment is not a causal essence. Furthermore, people can be impaired for a variety of reasons yet not have a psychiatric disorder. So impairment is not a sortal essence.

Jeff also raised a good question about justifying the inclusion of particular disorders in the domain. The imperfect community model does not seek to validate putative disorders as much as tell a historical story about how the psychiatric domain came about. In that story various symptom clusters were added to the domain because they were similar to other presentations already in the domain and they seemed to be relevant for the skill set of psychiatrists.

This historical story is problematic because it only begins in the 19th century with the rise of the asylum doctors. I could have just as easily begun it earlier. For instance, had it begun in the early modern era, rather than psychosis I might have started with melancholia and hysteria-hypochondriasis, but a radial structure would still have made sense.

On two issues, what I intended to say was not how Jeff read me. First, he claims that I commit myself to a hypothetical view of the course of human evolution and its teleological goals. I am not sure how I gave that impression as I critique Jerry Wakefield for speculating about natural functions.

Second, Jeff says I implicitly claim that personality disorders are in the domain because they are similar to "real" disorders. That is a metaphysical gloss that I did not employ largely because the term real disorder can be obscure.

Although the chapters in *A Metaphysics of Psychopathology* were all written to be understandable within the context of the book, a couple sections in chapter 11 were based on some of my earlier work. This work includes a 2011 article titled *The Clinical Nature of Personality Disorder* which was written as a friendly response to Louis Charland's claim that Cluster B personality disorders are moral, not medical conditions. This model was revised slightly in a 2013 book chapter co-authored with the University of Minnesota clinical psychologist Bob Krueger. It was titled *Personality Disorder and Validity: A History of Controversy*. A 2010 article co-authored with Nancy Potter titled *Personality Disorders: Moral or Medical Kinds – or Both* was also an important precursor to chapter 11.

Like Jeff suggested in his commentary, rather than use the term "real disorder," what we wrote about were the variety of factors make that personality disorder "clinically-relevant." The background assumption was that in the psychiatric domain, some disorders are more disorder-like and other less so. The models we articulated were summarizing the considerations offered in the professional and scientific literature that

make personality disorders clinically-relevant (or more disorder-like.) To summarize the models in brief:

The *vulnerability model* claims that personality disorders are clinically-relevant conditions in the same way that conditions such as hypertension and hypercholesterolemia are clinically relevant. They are clinically-relevant because they are risk factors for the development of less controversial disorders like depressive disorders, anxiety disorders, eating disorders, and psychosis.

The *pathoplasticity model* claims that personality disorders are clinically-relevant conditions because they affect the course and outcome of other psychiatric disorders. Those with a personality disorder develop other psychiatric disorders earlier in life, have more severe symptoms, and worse outcome.

The *spectrum model* claims that personality disorders represent milder expressions of the same genetic predispositions that underlie more serious disorders. Examples of personality disorders that have been hypothesized to exist on a spectrum include schizotypal, cyclothymic and depressive personality disorders.

The *decline-in-functioning model* refers to developmentally unexpected declines in function. This is not considered to be a feature of personality disorder, but of personality changes due to a) severe emotional trauma, b) a previous psychiatric illness, or c) a general medical condition such as a brain injury. This is largely a historical model related to the relationship between degeneration theory and personality pathology. But to some extent, if these symptoms are medical conditions in the context of injury and insult, they gain some medical relevance in the context of personality disorder.

The *impairment-distress model* argues that personality styles and traits can be considered disordered if they reliably lead to distress or impairment in social and occupational functioning. Based on what I wrote earlier in this response to Jeff, all of the other models would have to refer to this model in some way or another.

The *capacity failure model* emphasizes the failure to develop one or more psychological capacities that contribute to normal functioning. Unlike the decline-in-functioning model where capacities are lost, in this model they may never develop. For instance, the pathology of the psychopath may include the failure to develop certain moral capacities.

Jeff suggests that we should consider personality disorders to be disorders in their own right. I am less sure. Although I disagreed with Louis' Charland's claims about the exclusively moral nature of the borderline, psychopathic, and narcissistic personality disorders, I would not have written about what he said unless I had believed that it posed a legitimate challenge to psychiatric nosology and that others might be inclined to dismiss such claims out of hand. Personality disorders are controversial, in some cases because they do seem more bad than mad, or in other cases because they approach the boundary with normality. To say they are disorders in the own right does not do justice to imperfect distinctions that we use.

On the Nature of Grief and Depression (Gaier, Pickering)

In the past year, Ken Kendler, Michael First, and I have been working on a history of the debate about the bereavement exclusion during the development of the DSM-5. As I have revisited this topic since writing the book, let me briefly summarize my current understanding of the main points in the debate.

An uncomplicated depressive episode refers to cases that meet DSM criteria for a major depressive episode, i.e., two weeks of symptoms nearly every day, but does not feature severe symptoms such as suicidal ideation, psychomotor retardation, psychosis, or degradation of self-esteem. Beginning with the DSM-III, uncomplicated depressive episodes that occur after the death of a loved one were considered to represent normal bereavement, not major depressive disorder. This was called the bereavement exclusion rule.

Ken Kendler's research has indicated that the onset of a depressive episode is commonly preceded by stress. This made him wonder why one stressor – the loss of a loved one – was being treated differently from all other stressors. Working with Sid Zisook, he discovered that there were very few differences between uncomplicated depressive episodes related to bereavement and uncomplicated depressive episodes related to all other stressors. Independently, Jerry Wakefield and his colleagues discovered the same thing.

Kendler-Zisook and Wakefield each had different ideas about how to resolve this inconsistency. Kendler and Zisook's solution was to group uncomplicated mood disturbances related to the loss of a loved one with uncomplicated mood disturbances related to other stressors by removing the bereavement exclusion. In their view, they are all stress-related depressive reactions. Wakefield and colleagues' solution was to group uncomplicated mood disturbances related to the loss of a loved one with uncomplicated mood disturbances related to other stressors by extending the exclusion rule to all uncomplicated mood disturbances preceded by stress. In their view these are all normal reactions to stress.

Kendler is opposed to making major changes without overwhelming evidence, and because extending the exclusion would be a major change, he preferred making the smaller change of deleting the exclusion rule. Kendler also believed it was important to understand the role of stress in precipitating depressive episodes. Wakefield believed that the more important problem was to correctly demarcate the normal from the abnormal. In his view, the change Kendler and Zisook advocated for would increase false positive diagnoses, and the change Wakefield et al. proposed would reduce them.

This debate attracted a great deal of media attention and stimulated considerable activity in the blogosphere and journals. As you read through the arguments across the different platforms, three distinct views about the nature of depression emerge.

The first view construes intense grief and depression as lying on a continuum. This view is congruent with dimensional models of psychology in which normal mood and depression are continuous in the population. In the boundary region that transverses both, it can be difficult to decide what is normal or abnormal.

The dimensional model for depression is quite similar to the classical sorites problem in the history of philosophy. Sand scattered on the floor and a heap of sand are clearly distinct. If you gradually add one grain of sand to some sand scattered on the floor, eventually you will produce a heap. This raises a

question - at one point does adding one more grain of sand create a heap? Many thinkers believe that there is no precise point at which adding one more grain will constitute a heap. Lying between scattered sand and a heap is a vague boundary region where a precise distinction between non-heaps and heaps cannot be made. The same may be the case for making a categorical distinction between intense grief and mild depressive episodes.

With respect to Rachel's Cooper's comment about bivalent logic, I doubt that it can be applied to sorites type vagueness, i.e., whether something is a heap is not always either true or false. The claim that all vagueness is epistemic vagueness (meaning that there actually is a precise point at which adding one more grain of sand will create a heap) is more like a credo about what the world should be like.

The two other views construe grief and depression as qualitatively distinct. One of these views was promulgated by Jerry Wakefield. According to Wakefield, in a depressive disorder there is an objective dysfunction in the person, whereas in intense grief our normal loss response mechanisms are functioning properly. Grief and depression can look similar because symptoms such as depressed mood and inability to feel pleasure are not specific to depression; they are also common features of normal grief. Although we cannot directly observe dysfunctions, Wakefield proposes that we can indirectly detect them because they manifest as symptoms that are not proportionate to the stressor. Examples of symptoms that lack proportionality are suicidal ideation and psychomotor retardation. For him what are qualitatively distinct are stress-related uncomplicated depressive episodes and major depressive disorder.

A different view was articulated by Sid Zisook and Ron Pies. According to them, having the symptoms of depressed mood, lack of ability to feel pleasure, fatigue, concentration problems, and sleep disturbance most of the day nearly every day for two weeks or more is a depressive DISORDER. In contrast, during normal grief, a symptom such as inability to feel pleasure is not all encompassing; rather, it occurs in waves and alternates with positive memories of the lost love one. For them what are qualitatively distinct are normal grief and uncomplicated depressive episodes.

Robin Gaier

As Robin Gaier's commentary was largely an attempt to augment what I wrote in Chapter 10, to return the favor I will augment her commentary.

The first point I would like to make is on treatment. Gaier is certainly correct that much of the controversy about eliminating the bereavement exclusion was directed at the implications for pharmacological therapy, not counseling and psychotherapy.

For instance, Allen Frances is sympathetic to a dimensional model in which the threshold between normal and abnormal is fuzzy. For him, intense grief is like an unambiguous subthreshold condition. One of his main concerns was that giving subthreshold conditions diagnostic labels would result in aggressive treatment with medication, even if it was not needed. This risk for harm would be increased, he believed, once the drug companies spotted a potential new market and began advertising the benefits of medication during bereavement.

One of the arguments for deleting the bereavement exclusion was that it would make it easier for people in bereavement to obtain treatment if needed. Those who wanted to retain the bereavement exclusion did not believe that it interfered with people obtaining treatment because the DSM -IV was flexible. If a physician wanted to treat a patient with a bereavement-related uncomplicated depressive episode they could code them as depressive disorder not otherwise specified. Even if the clinical presentation did not meet criteria for a major depressive episode, they could code adjustment disorder with depressed mood. Let me also note that Jerry Wakefield even argued that some features of normal grief are inherently impairing, and in certain cases treatment may be appropriate.

One of Gaier's more important points is that the clinical task of diagnosis (determining if someone meets criteria for a disorder) is not the same as nosology (determining whether a particular phenomenon should be classified as a disorder). In other words recognizing that someone meets criteria for a depressive episode requires a different skill set than justifying the claim a depressive episode is a psychiatric disorder. Let me expand on this.

People who are trained in psychological assessment learn that DSM symptoms are selected, ideally, to be both sensitive to the presence of a disorder and specific to that disorder. Specific means they are indicative of that disorder only, and not indicative of other disorders. One consequence of these selection rules is that DSM diagnostic criteria do not provide a comprehensive or content valid description of a disorder. For instance, anxiety and depersonalization are common features of depression, but not specific to depression and therefore not DSM diagnostic criteria. This is one reason why being too literal about DSM definitions, or reifying them is a problem.

For this reason, in addition to being trained in diagnosis, it is important to be trained in the study of psychopathology – scientifically, conceptually, and historically. Assigning a diagnosis, developing a classification/nosology, and working with patients are somewhat distinct activities. Each of these can benefit from expertise in psychopathology.

The bereavement debate calls attention to the importance of understanding psychopathology in assigning a diagnosis when operationalized diagnostic criteria fall short. My book emphasized the role of understanding psychopathology in classification. Working with patients benefits from a more varied and clinically richer understanding of psychopathology than is encoded in the DSM -as emphasized by both Grant Gillet and Héctor Pelegrina Cetran in their commentaries.

In her commentary Gaier argues that information gleaned from the first-person perspective can also play a role in determining disorder status. I would agree. In his commentary Mel Woody points to my tendency to refer to all diagnostic criteria as "symptoms." Technically, symptoms refer to first-person reports and signs refer to observable behaviors, so first-person reports are included in the DSM. To some extent, however, the considerations Gaier explores about the importance of a first-person perspective are more relevant to psychopathology with respect to working with patients than for constructing and revising a general classification. For instance, learning from Mary's first-person report that some of her symptoms of depression are a manifestation of an existential crisis is therapeutically relevant, but this might not be a feature of depression-in-general. With a concept such as depression-in-general,

many particularities of individual cases are dropped out.

It is also true that a role for the first-person perspective has been mentioned in the literature on the bereavement exclusion over the years. For example, in her groundbreaking work on normal bereavement in the late 1960s and early 1970s, Paula Clayton claimed that even if those in mourning are depressed, they do not view themselves as ill. This includes people with a history of depressive disorder. In some cases, they want to feel bad about the loss.

So one possible consideration in making a diagnosis is whether or not the person believes that their distress is normal, or valuable. This is, however, deservedly controversial as a general rule. Some people may seek to occupy the sick role, even if they can function adequately. Others may ignore or deny symptoms that are unambiguous declines-in-functioning and threats to health. For instance, whether those with severe cognitive impairments related to a traumatic brain injury or with anorexia nervosa view themselves as being ill probably shouldn't play a very large role in diagnostic decision-making. For conditions that transverse the boundary between the normal and the abnormal, however, considering a patient's own norms might be a practically relevant part of clinical judgment.

Neil Pickering

Neil Pickering and I adopt a very similar perspective when choosing what to write about. We both are interested in picking a position that we are inclined to disagree with, such as antipsychiatry, but to also take it seriously rather than dismiss it. As a result, we call attention to what might be valuable in the opposing position, but also articulate reasons for not accepting it. We also adopt a non-essentialist perspective on disorder concepts, although we get there from different starting points.

However isomorphic our views, Neil's reconstruction of what I wrote in chapter 8 was not what I intended to say. I begin with two brief clarifications.

First, I did not intend to say that being a causal network makes something more disorder-like. For instance, some psychologists have suggested that well-being could represent a causal network. Being a causal network would not make well-being a disorder. From my perspective, the network model is interesting as a less essentialist alternative to the more traditional latent variable model, and has some important advantages for thinking about issues such as comorbidity. I am skeptical, however, about adopting it as universal model for all psychiatric disorders. Denny Borsboom seems to be moving in this direction and I am disinclined to follow him there.

Second, my historical reconstruction of how the domain of psychiatric disorder was built (as an imperfect community) was not intended to *justify* the putative disorder status of everything in the domain. It was primarily an attempt to describe how we got here and to note that the domain "hangs together," giving it an independent identity that makes it more than just what psychiatrist decide to treat.

The example I used at the end of chapter 8 was major depressive disorder. If we adopt a more dimensional perspective on depression, we should expect that there will be a boundary region that shares features with a normal mood disturbance on one side and a depressive disorder on another. What I am doing at the end of chapter 8 is asking, for an individual case manifesting depression symptoms that are part of the domain of psychiatric disorder, what features makes it more like normal cases or make it more like disordered cases.

Any specific occurrence of a psychiatric disorder can be seen as having bundles of features. These features are not limited to lists of sensitive and specific DSM symptoms. Not all features need to be present in every case, but the more of them that are present, the more confident we are in calling something a disorder. For instance, features such as a past history of depression, a depressive episode that appears without apparent cause, depression lasting more than six months, and an absence of compensatory factors all would make a mood disturbance more disorder-like. My list was not meant to be a complete list of relevant features, far from it.

Neil also asks a question about the boundaries of causal networks, raising an important issue I did not explore. For instance, we can expect that certain nodes in a depression network would have a causal connection to loneliness. Does this make loneliness a part of the depression network? The same could be asked of other correlated features, such as anxiety and depersonalization. How do we decide what is to be considered part of depression and what is to be considered something correlated with depression? This is important if we accept that DSM signs and symptoms are only partial representations of the phenomena being classified.

This is partly an empirical issue – especially in determining if the features are actually correlated. For instance, Neil refers to research by John Cacioppo and colleagues about the relationship between loneliness and depression. What Cacioppo and colleagues found was that loneliness measured in one year was positively correlated with depression in the next year, but depression measured in one year was not correlated with loneliness in the next year, i.e., loneliness predicted depression but not vice versa. This suggests that loneliness is a risk factor for depression, but the reverse is not true. That seems like a good reason for not considering loneliness to be part of depression.

My philosopher colleagues will tell you that the part versus whole issue is an important metaphysical problem. From the perspective of network theory, lonely feelings experienced by a person who is vulnerable to depression could be one pathway into a depression network, which it would then be part of. If we could intervene on loneliness to also ameliorate a case of depression, we might be more inclined to see it as part of depression. These are very preliminary thoughts and this requires further pondering. For now, I would say that we can draw the boundaries around an individual depression network widely (including loneliness) or narrowly (excluding loneliness). If we drew the boundaries differently in response to different goals, each would then be a practical kind in my menu of kinds.

The Biological Revolution and the Current State of Psychiatry (Hardcastle, Waterman, Porter, & Woody)

In the 1960s Thomas Szasz triggered an intense controversy by declaring that mental illness was a myth. Also during this decade, it became publicly evident that American psychiatrists could not reliably agree on something as funda-

mental as whether a patient has schizophrenia. Thus began a still ongoing conflict about whether psychiatry is a legitimate medical discipline.

During the same decade, a minority of psychiatrists believed that, under the dominance of the psychoanalytic paradigm, psychiatry was not a legitimate medical discipline. In the early 1970s, some members of this minority at Washington University in St. Louis began publishing work that contributed to what some have called a revolution. Surprisingly quickly, this revolution swept away the psychoanalytic hegemony in favor of a more biologically-oriented psychiatry. Although psychopharmacology had been introduced in the 1950s, it was still a toddler in the early 1970s – but ready to take off with the development of new classes of drugs.

The DSM-III is often, incorrectly, seen as being designed to promulgate this revolution. The main architect of the DSM-III, Robert Spitzer, was not trained as a biological psychiatrist but as a psychoanalyst. He had also been a psychology major in college and preferred doing psychometric research, such as developing rating scales. In fact, at Columbia's New York State Psychiatric Institute he worked in psychologist Joseph Zubin's biometrics department and his main collaborator was the psychologist Jean Endicott.

The psychiatrists in St. Louis were themselves developing an operational approach to diagnosis that would increase reliability and, they believed, assure that people in the same diagnostic category shared the same illness. This cohered well with Spitzer's interest in psychological measurement and many people associated with the St. Louis Group became members of his leadership team for developing the DSM-III. Although Spitzer did not intend the DSM-III to usher in a biological revolution, and the DSM was not biologically-based, several members of Spitzer's Task Force saw the DSM-III as supporting the goals of the biological psychiatrists.

The biological revolution, however, has resulted in an unforeseen irony. During the years of psychoanalytic dominance, psychiatry was a sought after specialty and attracted some of the brightest medical students into its ranks. This was also the case in the early days of biological psychiatry. Thirty years into the biological revolution, however, psychiatry has become one of the least competitive and least lucrative medical specialties. This situation does not look like it will improve soon because the development of new and better drugs has stagnated, and even the drugs that were supposed to be better than what preceded them have mostly turned out to be different, not better.

Part of psychiatry's problem is due to the economics of health care. Many psychiatrists spend their days, unsatisfyingly, seeing one patient after another for brief medication management sessions. According to current conventions, one way to make a drug more effective is to boost it with a second prescription and then another and then another. This practice is also contested. I have seen many people who function well on multiple medications, but also encountered others on such an intense polypharmacy regimen that, at times, rather than feeling normal, they feel muted. For a variety of reasons, economics included, the biological psychiatrists' strategy for enhancing the reputation of psychiatry within medicine has had the opposite effect.

Valerie Hardcastle

Valerie Hardcastle claims that discoveries about neural function can potentially contribute to a better, more refined conceptualization of psychological phenomena. This is sometimes called biological-psychological co-evolution. One of my favorite examples of a co-evolutionary process occurred in addiction studies, specifically in the research supporting the distinction between liking and wanting. This distinction has been popularized by Kent Berridge and colleagues based on their discovery that liking and wanting have different biological signatures. With respect to addiction, if an addict reaches a satiation point where the drug is no longer associated with pleasure (liking), he or she will still have a strong desire (wanting) for the drug and continue to use. Prior to this discovery, it was assumed that wanting a drug was a function of the reward of pleasure, but wanting appears to be a reward system phenomenon that is independent of pleasure.

I agree with Valerie that understanding the biology of the reward system should be relevant for understanding grief and depression. Other than saying that grief reactions might, like pain and addiction, involving alterations in our reward system, however, she does not say much about grief, complicated grief, and depression.

Others have said more. For instance, in the 1980s Donald Klein observed that there are to two distinct grades of depression. In the milder version the depressed person does not anticipate pleasure (wanting), but they still can enjoy typical pleasurable experience when they occur (liking). In the more severe version, the depressed person does not anticipate pleasure nor enjoy typical pleasures when they occur.

This distinction within the reward system has been part of how I have thought about depression for over two decades. It is quite useful. Klein was also one of his generation's leading biological psychiatrists. Biological psychiatrists, therefore, have known about this distinction for over twenty years, but it has not led to the isolation of diagnostically useful biomarkers for depression.

How is it that promising leads such as anticipating pleasure versus enjoying pleasure have so far tended to not work out as expected, i.e., what are the reasons that diagnostically useful biomarkers have not been discovered here or elsewhere in psychiatry. Tentatively, from the perspective of clinical psychological science, one of these reasons might be a problem with external and ecological validity. When you experimentally isolate a particular structure or functional circuit in the brain, that signal gets lost in the noise that exist outside that artificial experimental situation. For instance, neural activation may be somewhat "pleiotropic" for psychological function, depending on what else is activated. This external validity problem is enhanced further by the high levels of measurement error that are tolerated in imaging studies – as has been pointed out by Scott Lilienfeld.

As I described in my preliminary remarks, there exist different theoretical perspectives on the nature of grief and depression. If either Zisook and Pies or Wakefield is correct about grief and depression being qualitatively distinct, then we could be more hopeful that the psychological distinctions we make might map onto isomorphic distinctions somewhere at the biological level. If, however, the two exist on a continuum with a fuzzy boundary region separating clear cases, we might expect that the same gradations that are observed at the psychological levels will occur down

below, and a categorical distinction between normal and abnormal will be difficult to make at lower levels as well.

Where do such considerations leave Locke's concept of workmanship that was introduced in the opening section? Let me discuss this with reference to a psychological distinction that was initially made using a biological intervention, the distinction between panic disorder and generalized anxiety disorder. Ken Kendler has written about this in chapter 38 of *Philosophical Issues in Psychiatry IV* edited by Kendler and Parnas for Oxford University Press in 2017.

In the DSM-II of 1968, the category of anxiety neurosis referred to anxious over-concern that often included feelings of panic. The anxiety also manifested in any circumstances rather than being restricted, like phobias, to specific situations or objects. In the DSM-III of 1980, anxiety neurosis was split into panic disorder and general anxiety disorder (GAD). The justification for this split was Donald Klein's discovery that the tricyclic antidepressant imipramine was specifically useful for treating inexplicable panic attacks. Klein referred to this approach to classification as pharmacological dissection.

In addition to being biologically meaningful, this distinction between panic disorder and GAD is psychologically meaningful. The different therapeutic approaches adopted for panic disorder and generalized anxiety disorder further validate the distinction.

The validity of a panic disorder syndrome was further confirmed by the discovery that sodium lactate infusion was more likely to induce a panic attack in patients with panic disorder than in both normal controls and patients with other psychiatric disorders

As Kendler reports, as new validators were selected to further test the distinction, the results grew murkier. For instance other drugs known to induce panic attacks are not so specific. Administration of carbon dioxide induces more panic attacks in people with panic disorder than all other comparison groups, but it also induces a high number of panic attacks in those with generalized anxiety disorder and premenstrual dysphoric disorder. With respect to pharmacological dissection, the newer classes of antidepressant such as SSRIs and SNRIs are useful for both panic disorder and generalized anxiety disorder, are as the higher potency benzodiazepines. In addition, family studies in behavioral genetics indicate that panic disorder and generalized anxiety disorder aggregate separately, but in structural equation modeling where the variance is partitioned into genetic and environmental factors, they appear to share the same genetic risk factors.

What implications does this have for the workmanship of human understanding? Once a signal is detected, an important task for workmanship is to boost that signal in ecologically realistic settings. As Kendler notes, in both the DSM-III-R and the DSM-IV the diagnostic criteria for generalized anxiety disorder were altered, in part, to create a greater separation between panic disorder and generalized anxiety disorder. For instance, in DSM-III-R the minimal duration criterion for generalized anxiety disorder was increased six fold, and the focus of worry was specified to not be about panic. In the DSM-IV, the number of symptoms was reduced from eighteen to six by deleting any motor symptoms and autonomic symptoms that were related to panic.

Using my terms from a 2012 chapter titled *Progress and the Calibration of Scientific Constructs: The Role of Comparative Validity*, the DSM's generalized anxiety disorder construct was *calibrated* to achieve the goal of clearly differentiating generalized anxiety disorder from panic disorder, scientifically and clinically. Calibration is a form of workmanship. It is not that the DSM-IV construct for generalized anxiety disorder corresponded to a definite world structure and the DSM-III and III-R constructs were fictions. Indeed, deleting the references to panic in generalized anxiety disorder may be a distortion. The value of the new DSM-IV construct for generalized anxiety disorder is that it better coheres with a number of scientific and therapeutic goals.

A very different sort of problem is raised by Valerie Hardcastle's claim that science should define disorders. I would like to clarify my position here. Once we demarcate disorders such as major depressive disorder and panic disorder, we should seek to scientifically understand the mechanisms that produce and sustain those phenomena, seek to map their rates of occurrence in a population, and develop empirically valid treatments.

That is not the same as saying that scientific research alone determines whether a particular condition is a disorder. Consider sexual orientation. If some researchers at the NIMH were to discover unambiguous biological substrates for being lesbian/gay versus heterosexual, would this mean that being lesbian/gay is a psychiatric disorder? Would these substrates constitute the disease etiology of homosexuality?

Most thinkers would say no. Different kinds of evidence suggest that being lesbian/gay is better considered a biologically-based normal variation, not a disorder. For instance, lesbian/gay relationships are not compulsive and short-term as once considered. This too is a research finding, but its informational value also depends on norms about healthy relationships.

For the present, I side with thinkers such as Derek Bolton who are skeptical about fully naturalizing the concept of disorder. For instance, Bolton argues that psychiatric disorders are identified for being violations of psychological norms – as ways of interfering with the valued activities of daily life (i.e., distress and impairment). The initial work making the normal versus abnormal psychology distinction is the perception of particular kinds of norm violations, and without either current violations or possible future violations, the psychiatric disorder attribution could not be justified.

For severe depressions that involve deficits of wanting and of liking (called the melancholic subtype), the norm violations are numerous. For milder deficits, similar internal states may be more or less incapacitating across people depending on their respective vulnerabilities and strengths. For instance, two people may be experiencing a mild depressive reaction during bereavement. The first may have good social support, an engaging job, and an internalized sense of worth. The second may be isolated, working an unsatisfying job that is of much lower status than he prefers, and unable to regulate esteem autonomously. It is at least possible that the first person manages the mood disturbance, whereas for the second person it becomes unmanageable and judged to be a disorder.

Scott Waterman

Scott Waterman was one of those bright students attracted to the new biological psychiatry and its mission of making psychiatry more scientifically rigorous. He spent his career in a medical school overseeing the education of aspiring physicians. For many of those years he did not believe that the DSM was a useful tool for education, and eventually came to believe the same thing about some aspects of the current iteration of the biomedical model itself.

In the book I proposed a radial structure for the domain of psychiatric disorder. In this radial structure, psychotic disorders occupy the center of the domain. As you move away from the center and toward the boundary with normality, putative psychiatric phenomena get less disorder-like.

The concern voiced at the end of Scott's review of the book, originally published by *Metapsychology Online Reviews*, is that to treat psychotic states such as schizophrenia and bipolar disorder as diseases is to shove them into a procrustean bed that, in practice, encourages adopting an overly narrow view of these phenomena. For instance, antipsychotic medication nearly always produces unpleasant side effects, and for some patients the side effects are more prominent than the therapeutic effects. These clinical features tend to be minimized in the biomedical disease model.

I largely agree with Scott. Given that a cure seems to be out of the question for now, an alternative goal is to help people live as meaningfully and freely as possible. It turns out that with effort, some people can learn to live with symptoms adaptively rather than having them medically suppressed. This rehabilitation approach is similar to the kinds of services offered to people with traumatic brain injuries, – another ailment where cure is currently not possible.

I am still inclined, however, to place psychosis near the center of the psychiatric domain, including schizophrenia, major depressive disorder with psychotic features, and bipolar I disorder (i. e. manic depressive illness). Florid psychotic states clearly represent developmentally unexpected declines in function, their onset can be experienced as an affliction, and in psychosis people are readily afforded the privileges of the sick role – including a diminishment of responsibility. They are not mythical illnesses in the Szaszian sense.

Should we try to prevent schizophrenia and bipolar disorder from occurring if we could? I would say we should. That intervention question, however, becomes more difficult to answer once the spectrum concept is introduced. A spectrum refers to various graded manifestations of a shared genetic vulnerability. For instance, schizotypal personality is on the schizophrenic spectrum and cyclothymic personality is (probably) on the bipolar spectrum. It is arguable that these personality styles could be considered normal variations rather than disorders and left alone – even if they involve transient distortions in reality testing. I suspect, however, that there would be a good deal of consensus about considering sustained psychotic episodes to be disordered states and preventing them.

Interestingly, I am also inclined, like Scott to be cautious about applying the disease label, especially if disease is conceptualized in an essentialist manner. Rather than there being a universal disease nature that is equally present in all things called diseases, the concept of disease refers to a family of different states. If the concept of disease has a radial structure, I might place infectious disease such as tuberculosis near the center. Also near the center would be genetic diseases such as Huntington's disease and autoimmune diseases such as type I diabetes. I would think allergies, poisoning, and heat stroke would be further way from the center, as would psychosis. Hypertension and hypercholesterolemia would be nearer to the fuzzy boundary with normality, as would a grief-related depressive reactions and some personality disorder diagnoses.

Doug Porter

Doug Porter also entered psychiatry in the heady days of the biomedical revolution and has spent his career working with patients suffering from major mental illness. As someone who works with such patients, he understands the value of medication. Yet he has also become disenchanted with many assumptions of the biomedical model, and especially of its narrow vision regarding the scope of psychiatric practice.

In his commentary Doug focuses on the interaction between the essentialist bias, the metaphysics of natural kinds, and misplaced literalism. In doing so he raises a question about the proper object of treatment. A cardiologist treats mitral value prolapse as a technical problem. A dentist treats a dying tooth as a technical problem. They are each able to achieve technically amazing things because of how much they have learned about the heart and the tooth. For the most part, one mitral value is like other mitral valves and one instance of infected pulp is like other instances. By analogy, it could be argued that psychiatrists should treat the clinical entities of major depressive disorder and PTSD as technical problems, but being able to do so will depend on learning more about the brain, or about cognitive-affective psychology.

Given the success of the technical approach elsewhere, I do not see how it can be avoided in psychiatry. The clinical entity perspective (whether construed as a natural or practical kind) can help us see things about major depressive disorder or PTSD that we did not see before. The problem with the technical approach is that it has not worked as well as expected. It is now in vogue to blame this failure on the invalid categories of the DSM. If we had a better nosology, the thinking goes, the technical success enjoyed elsewhere in medicine would accrue to psychiatry.

I am less sure. Much of medicine probably involves more guess work and trial-and-error than common sense essentialist ideas about disease would lead us to expect, and psychiatry is not different from many other specialties in this respect. But Doug points us in another direction – toward the view that the problem may not be the invalid categories of the DSM, but the complexity of psychiatric distress and impairment themselves.

One has to be careful that talk about the "complexity" of the psychiatric domain is not a excuse for an obscurantism that is resistant to change and progress. Yet, it remains true that psychiatry has almost never turned out to be as tractable as expected.

There are two aspects to this complexity. The first closely tracks my notion of nominalism in which our general concepts are inadequate to many particulars of experience. The partialness of concepts is one reason that entertaining multiple perspectives can be helpful.

The second aspect is that the goals we adopt can influence which aspects of phenomena we weight more heavily. As Doug points out, the ultimate goal of psychiatry is to reduce the suffering and impairment related to psychiatric distress. The goal of reducing suffering tends to give individual features of a case more importance than they would receive in the clinical entity approach. For things like grief-related depression and PTSD, for instance, the individual content of the person's thought (this lost loved one, this traumatic event) become part of the treatment.

Should psychiatric disorders be studied as clinical entities or is the clinical entity view an illusion because the nature of psychiatric disorders cannot be separated from the context of the individual psyche, the society, and the culture in which they appear. I would say that clinical entities are not illusions. For example, by observing many cases of an epidemic and discerning a common clinical entity, Sydenham learned something that the individual-centered Galenists never saw. In psychiatry, however, to absolutely separate disorders from their context is to misunderstand them. As Doug's commentary indicates, they are not isolated from what else is going on around the person.

Melvin Woody

Melvin Woody's introduction of semiotic considerations takes us into deeper waters. From a classification standpoint, symptoms are usually considered fallible indicators of some underlying pathological process. In clinical psychology's construct validity tradition, underlying pathological processes are modeled as latent variables. In the causal network tradition discussed by Neil Pickering, disorders are produced and maintained by causal relationships between symptoms. Rather than observable indicators of underlying processes, symptoms are considered to be parts of disorders.

In addition to issues about whole and parts, the latent variable versus causal network distinction raises question about the nature of properties. It is probably obvious that I would not view properties as universals.

Mel's comments orient us in different direction, toward symptoms as signifiers. A key idea here is that we tend to think that disorders are entities out there and symptoms signal their presence, but signification also involves an act of interpretation. When we particularize something such as anhedonia, we are isolating one aspect of what is 'ontologically abundant.' To say that anhedonia signals major depressive disorder is to notice a relationship between one thing and another, but that is not the only possible relationship that we can notice. This makes noticing an interpretation.

As I understand him, Mel says that anhedonia can be interpreted to symbolize many different things. I would argue that a kind concept such as major depressive disorder is also an abstraction from what is ontologically abundant, and what it "symbolizes" is partly also a function of interpretation.

For example, when we say anhedonia signals depression, does that mean that it signals an affliction – something forced upon me and beyond my control, or could it signal a kind of self-expression – an act of giving up or withdrawing? Indeed, both interpretations might provide us with important information. In this respect, Mel's claims about the ontological status of symptoms recalls Locke's workmanship of the human understanding, and even more so Nelson Goodman's metaphysical notion of worldmaking.

I have often written about our naming practices, but Mel helpfully shows that names are also interpretations. Just as phenomena are not constituted by names and concepts, phenomena are not constituted by interpretations. In the book, I do not discuss this using the language of semiotics, but my claim that the notions of natural kind, practical kind, historical kind and normative concept are cognitive resources can be used to reveal different information about the phenomena of psychiatric disorder is making a similar point.

Mel also calls attention to how disorders are not the only things that symptoms indicate, and to think of symptoms only as signifying disorders is to view them (and disorders) too narrowly. His thinking here has been inspired by Arthur Kleinman's distinction between illness and disease. By illness, Kleinman means the variety of ways we experience and understand medically-relevant human suffering. Disease is a professional concept in which illness is understood through the lens of some theory of disorder. Particularly when the information gained from a disease model does not heal, an understanding of illness can contribute to better patient care.

Not only is psychopathology broader than classification and nosology, as the humanist Kleinman notes, human experience is broader than psychopathology. I would add broader than does not mean independent of. Our understanding of psychopathology without classification would be more narrow and shallower, and likewise our understanding of human experience without psychopathology would more narrow, and shallower. In the next section I will say more about the relationship between classification and psychopathology.

Psychiatric Classification is not the Same as Psychopathology, but it is a Substantive Part of it.

In my response to Robin Gaier, I stated that diagnosis, classification and working with patients are somewhat distinct activities, but all benefit from an understanding of psychopathology. Although Grant Gillet's and Héctor Pelegrina Cetran's commentaries could have fit into both of the previous sections, as each takes a more critical stance, I have grouped them separately.

In titling the book A Metaphysics of PSYCHOPATHOLOGY, I opened myself to scrutiny. Both Gillet and Pelegrina Cetran argue that my account is inadequate and offer their own substantive views on the nature of psychopathology.

The philosophy *in A Metaphysics of Psychopathology* was drawn from the history and philosophy of science and largely applied to psychiatric classification. Focusing on psychiatric classification as I did imposes constraints. Classification systems such as the ICD and the DSM should not be used as textbooks of psychopathology. The ICD has no aspirations to be a textbook. The DSM, however, offers more than a listing of diagnostic criteria. It includes sections on development and course, risk and prognostic feature, and cultural-related diagnostic issues, making it textbook-like.

Classification, however, is only part of psychopathology. An understanding of various theoretical perspectives on disorder constructs is another. These, perspectives can be found in both the professional and scientific literature. A

familiarity with the history of psychopathology is also important. Ideally one's understanding of psychopathology should be augmented with perspectives from the study of normal psychology, social work and sociology, anthropology, political and social criticism, history, and philosophy. As important as anything, is working with patients.

Although classification is only a part of psychopathology, it is a necessary and substantive part. As a result, the wide variety of commitments that are adopted for classification such as the causal versus descriptive, essentialist versus non-essentialist, and naturalist versus normativist perspectives have direct influences on our standards for "relevant," "real," and "valid" psychiatric disorder constructs. In my responses to Gillet and Pelegrina Cetran, I hope to illustrate the kind of substantive contribution that classification theory can make to psychopathology.

Grant Gillet

The first part of Grant Gillet's commentary is partly a reconstruction, from the perspective of a different philosophical paradigm, of various assertions I made in the book. For instance, he offers a neurological and ethological account of the nominalist view of concepts as partial representations that both reveal and conceal phenomena. His Rule Maker claim is consistent with my emphasis on how dependent we are on authorities in forming beliefs. Asserting that a touch of the real can intrude and thus compel the Rule Makers to modify their beliefs is compatible with my thinking about mind-independence. Finally, his notion that scientific concepts present the world in ways suited our interests and practices has a strong pragmatic flavor to it.

However, Grant is critical of the imperfect community model as a theory about the nature of psychopathology. Using an example of a young man with conversion disorder, he says that we can explain the conversion symptoms as a pattern of brain activity, but only by talking to this person, and learning about his history and his personal situation can we begin to understand the reasons for this patterning. He poetically calls this later perspective the discourse of the soul. The implication is that what we attend to in the discourse of the soul are not mere epiphenomena, but real features of psychiatric disorder as experienced by persons rather than as described in diagnostic manuals.

I agree with Grant that psychiatrists, psychologists, and other mental health processional should interact with individuals, not just tokens of a disorder, but I do not agree that the imperfect community model is too sparse to be relevant to achieving this humanist perspective. Just the opposite is the case.

As Grant's perspective seems to be partly based on his training in neurology, let me describe my own training history. In some psychology programs, clinical training begins with administering structured interviews to establish a diagnosis. In other programs, it begins by learning to treat a condition such as depression using an empirically-supported treatment manual. The emphasis is on disorders. My training in all-purpose psychotherapy was quite different. For the first couple of years I was taught to attend to the developmental challenges typical of a client's age and/or life stage. Development can be divided into career, social, and personal development – each considered as a distinct domain. We were also taught to attend to gender, race, and cultural factors.

In supervision, the focus was not on establishing a diagnosis but on the process occurring between therapist and client. Whatever the merits or demerits of this approach, one merit was that I was not taught to initially view a client as a token of a disorder. When disorder constructs were introduced, they were partly seen as being embedded in these other domains. This was a pluralistic model in which taking account of different domains could reveal unique information about the person.

Let us combine this developmental perspective with the notion of symptoms embedded in networks by looking at Grant's example of conversion disorder. Grant's patient is a male with a highly dominant spouse, and he is having an affair. He is likely in his early 40s. Asking about what developmental tasks is he facing with respect to the domains of career development, social development, and personal development might be revealing. The same with respect to general cultural factors. For instance, what are his views regarding being a man, his views about marriage, or his ideas about morality and religion?

Another relevant domain is that of personality. For a diagnosis of hysteria, we might expect such a person to be extroverted and attention seeking, highly impressionistic, distractible, and lacking in factual knowledge. He might be suggestible and emotionally expressive, although his emotions may have a performative aspect and be rather shallow.

To the extent that any of these features apply to this case, they could be relevant to working with this patient because the developmental, cultural and personality domains are important individuating factors. At the very least they taking account of them can contribute to the establishment of a decent working alliance. All these factors are real, and they make this person more than a token of conversion disorder. That is not all there is, and more could be added, but neither is it sparse.

The imperfect community model refers to the notion that the class of psychiatric disorders hangs together, but not because of a shared essence. The notion of networks embedded in networks augments this by emphasizing that the nature of disorders cannot be solely located in fixed internal properties. The multi-domain approach that I learned in my psychotherapy training was one of the frameworks that informed my thinking about the domain of psychiatric disorder.

The imperfect community model, however, was proposed for mostly philosophical purposes with respect to psychiatric classification. In the book, I introduced the imperfect community model by referring back to my notion of instrumental nominalism from an earlier chapter. The problem with general kind concepts is that important particularities are dropped out, and if the concept becomes reified or is taken too literally, it can distort the phenomenon. However, we also learn about things by grouping them together under kind concepts and seeing what they have in common, so kind concepts can be useful instruments.

Darwinian non-essentialists view a species as population of individuals that vary. This notion that "variation is what is there" can also be applied to kind concepts such as hysteria, depression, and schizophrenia, often under the auspices of family resemblance models and/or radial categories. Depression and schizophrenia are analogous to species

in biological classifications. The imperfect community model moves up from the species level to a genus level by applying this radial structure to the domain of psychiatric disorder itself. The domain was built by an expansion of its boundaries to include symptom clusters that resembled what was already in the domain in a variety of ways, but there is no one way in which they are all alike. The psychiatric domain is itself embedded in other domains – personal, interpersonal, cultural – setting up the possibility for significant individual variation.

By taking this notion of "variation is what is there" and making it a part of the general concept of psychiatric disorder, the resources for resisting reification and misplaced literalism become an inherent part of the concept itself. That was the goal anyway.

Héctor Pelegrina Cetran

Pelegrina Cetran's perspective represents the kind of theoretically rich understanding of psychopathology that is less common today, especially in the U.S. Responding to his commentary is more challenging because he brings very different metaphysical commitments to the material than I do, and he also comes to a different conclusion about essences.

We agree that the various essentialisms associated with Plato and Aristotle distort our understanding of psychopathology. I argue that this is due to a cognitive bias that we all share. In Pelegrina Cetran's view, the important problem is not a disposition to expect that the world is pre-organized into a collection of natural kinds that share an identity-determining nature; rather the metaphysics of kinds-entities-substances is itself problematic because it is the framework in which an illegitimate subject versus object split and reductive mechanistic accounts emerge. From his perspective, modern philosophers of both the empiricist and idealist sort continue to adhere to this ontology of substances.

From a pragmatist standpoint I readily admit that his alternative – a process ontology or a general systems ontology, can be informative, as can ecological models of psychology. The network model that I discussed in chapter 8 is compatible with a systems theory approach. Some of my thoughts expressed in the book were developed at a workshop bringing together advocates of network theory with experts in dynamical systems theory. My ideas about depressive episodes that are locked-in being more disorder-like was inspired by the dynamical system theory of critical tipping points and alternative stable states.

We are social creatures from the moment of birth. In addition, both communitarian and postmodernist critiques suggest that the isolated knower is a myth. Although I am wary of the anti-modern, illiberal commitments of postmodernism, some of its ideas are informative. For instance, many of our cognitive achievements occur through a process of imitation and borrowing, including what we might even consider our "original ideas."

I too would question an ontology of substances, nevertheless, an ontology of individuals seems valuable to me. In part, my views may reflect the emphasis on individual differences that is paradigmatic of American psychology. Although we are social creatures, our relationships are not literally symbiotic and separation from others is something we all have to negotiate. Even if our ideas come about as a kind of imitation, once they become internalized they become ours. We can also imitate those who reject tradition, and in doing so learn that the freedom to choose to be different is hard to exercise because it can increase separation. Such considerations readily suggest an ontology of individuals.

Turning to the topic of essentialism, my and Pelegrina Cetran's different metaphysical commitments are partly correlated with discrepant views about what might be called psychiatry's "identity issue." Pelegrina Cetran claims that psychiatry is a young, even immature discipline. On my reading, his essential activism expresses a view about what a more mature psychiatry would look like.

I am not sure, however, that the "young discipline" interpretation of psychiatry is historically accurate. The birth of contemporary medical specialization occurred in the 19th century. In France, an early form of psychiatry (alienism) was one of the first specialties to appear. The establishment of University-based medicine in Germany was even more important. As a science, the discipline of psychiatry is older than many successful sciences such as molecular genetics and robotics.

There is currently widespread dissatisfaction with psychiatry, but rather than it being a feature of psychiatry as a young discipline, it is a feature of failed expectations contingent upon the inherent complexity of psychopathology. Pelegrina Cetran refers to this complexity himself in noting that psychopathology is a multi-disciplinary endeavor.

What about Pelegrina Cetran's notion of essences as dynamic processes shaping the structural identity of entities. I am constrained in how much I can say because it is hard to get a sense of how his ideas would work in practice. The intricate mélange of systems theory, enactivism, development psychology, phenomenology and more that constitutes his metaphysical framework is difficult to decipher from only reading a 5000-word essay.

According his "essential activism," the nature of psychiatric disorder is *a destruction or threat of destruction of the identity of a living entity, based on a dis-appropriate structure of behavior, on a misuse of the information provided in normal behavior.* From an empiricist perspective that is a quite lofty abstraction.

The same is true for *in major depression the predominate feature is the conviction that one's personal life is threatened by the inaccessibility of resources or possibilities for realizing them in this world* and *the pathological element in the manic phase is the biographic consequences of his unmeasured and inappropriate behavior with respect to his world and with respect to the own resources.*

The shared idea in these definitions is that symptoms are part of a person-environment system and cannot be understood in isolation. Persons are also agents in this model who are continually constructing themselves and their identities in congruence with the environment. Psychopathology, he suggests, is a process of deconstruction.

Disorders may be deconstructive in his sense, but a lot of challenges create disharmony without being psychiatric disorders. Why deconstructive processes (as essences) are specifically identity-determining for psychiatric disorders needs more explaining. Without such an explanation, the claim that disease is deconstructive and health is presumably constructive works like an ad hoc metaphysical augmentation that depends on

the abnormal versus normal distinction already having been made.

As I noted in the opening section of my responses, metaphysical minimalists worry about people 's tendency to adopt about abstract concepts a feeling of certainty that is only appropriate to the particulars of daily life. Inappropriate conviction was one of the things for which the psychoanalysts were criticized. Their certainty about the universal Oedipus complex is a good example of misplaced conviction. One could agree that something looking like Oedipal dynamics might occur without making the Oedipus Complex into a human universal. In the same way, an impairment of our active attempt to self-actualize in harmony with our ecology might be a particular feature of psychiatric disorder that we can usefully notice, but I would not inflate it into a universal, nor anoint it an essence.

(An 11th hour) Response to Jim Phillips' Editor's Column)

Jim Phillips' claim that correspondence and coherence are inextricably entwined is largely consistent with the general ideas I have been attempting to articulate. My argument against correspondence to the facts as a universal standard of truth was not meant to replace it with another universal standard such as coherence with what else we accept to be true. It was an argument against taking correspondence to be the sole standard.

Let me note, however, that my notion of coherence and Jim's appear to differ. Jim combines coherence with consensus – claiming that if a community of psychiatrists agreed that slaves who repeatedly tried to escape slavery were disordered, that consensus could be shattered by facts showing that the consensus was not true.

In contrast, my notion of coherence refers to coherence with what else is accepted to be true. Some people might say coherence with what else is known to be true. Coherence does not refer to agreement within a community – which can be epistemically flimsy. More rigorous than consensus within a group, coherence includes agreement with other facts, but seeing facts depends on background assumptions, theories, other facts, etc. For instance, the theory of evolution is coherent with the facts of the fossil record, but those facts belong to theories in geography, atomic physics, and so on. Coherence does look to agreement, but not the kind of agreement based on group consensus and conformity.

Furthermore, correspondence with the facts by itself did not lead to the rejection of the Drapetomania construct. Even if it had been widely accepted, Drapetomania could not survive the abolition of slavery. Abolitionism was argued for both on religious grounds and in conformity with the liberal aspirations of the Enlightenment and the Declaration of the Rights of Man. One likely reason that slavery was abolished was because it was not coherent with some versions of Christian morality or with Enlightenment values. So, Jim correctly predicted that I would say that rejecting Drapetomania was contingent on a specific set of coherence relations coming to be seen as more important.

The force of these coherence considerations (as opposed to facts) may partly explain some of Cartwright's own arguments in his infamous essay. With respect to the religious grounds, Cartwright offered a biblical justification for black people being slaves by nature. With respect to the Enlightenment political values, Cartwright argued that his claim that black people are not suited to freedom and self-rule is proven by the social dissolution that ensued when former slaves (inspired by the Declaration of the Rights of Man) took control of the French colony of Saint-Domingue (later renamed Haiti). I surmise he made these claims because he realized that the most damaging arguments against his views were based on considerations of coherence.

I also acknowledge the important role that facts can play in breaking up coherent networks of beliefs. Various philosophers (Duhem, Quine, Putnam, Longino, Lakatos, etc.,) have shown that isolated facts bear a complicated relationship to networks of abstract beliefs, and in agreement with them, I do not hold that facts inevitably speak for themselves. All the same, networks of principles and their associated "facts" can be dogmatically held and experiences that are anomalous with such networks can play important roles. Fact-based experiences, testimony, and narratives regarding Black slaves as persons (having emotions, talents, values, and aspirations,) were important factors in rejecting Cartwright's "slave by nature" notion, just as personal experience and narratives about lesbian and gay people have recently played a role in changing attitudes about sexual orientation.

Jim also made some interesting and important points about my notion that if we cannot acquire any information about a supposed matter of fact, then we cannot treat it as a fact. Hence, if we cannot obtain any information about what Arthur Conan Doyle ate for breakfast on a specific day in 1903, then for practical purposes, it is not a factual matter.

Jim's counter example refers to the taking of his morning pills. Jim is supposed to take his pills in the morning, but he finds that by the time night arrives, he cannot always remember if he took the pills. Whether he did take them, Jim says, is still a matter of fact. He cannot make a valid factual assertion about whether he took his pills, but it is a matter of fact nevertheless.

With some caution, I agree, but do not believe that this example is analogous to the Conan Doyle example. First, consider defining facts according to what philosophers call a God's eye point of view. From a God's eye point of view, what Conan Doyle ate for breakfast over 100 years ago, whether a star is currently exploding more than 15 billion light years away, and the temperature in New Haven, Connecticut on July 4, 2055 are all presumably matters of fact. I don't see how that perspective on facts can be practically relevant to us.

For us, to call something a fact is to assert that we are compelled to accept that particular claim about the world no matter what we want to believe. That is why facts are important in contrast to fantasies and wishes. Is whether Jim took his morning pills a fact in this respect – independently of the metaphysics of a God's eye perspective? Indeed, it is because we can acquire information about whether he took the pills and it may be practically important that we do so.

For instance, if Jim gets to the end of the month and still has 20 pills out of his original 30, then we have information about his taking of the pills. He has not been taking them regularly. He could even track the number of pills in the bottle throughout the month, which is what the pill box does on a daily basis.

More importantly we can also ask what the pills were for – and it may

matter quite a bit whether Jim takes them. If they are blood pressure pills and he finds that his blood pressure is spiking by 8PM, that blood pressure reading is providing information about whether the pills were taken. The measure of his blood pressure may offer more valid information about taking the pills than his memory. For us, this information is accessible and relevant, and thereby factual in the way that matters. That was not the case with the Conan Doyle example.

Let me also say that mattering to us does not make something a fact – to believe that would be to confuse fact with interest and preference. There are many more facts than we will ever assert, and most of them are not relevant. Facts about blood pressure are relevant.

In Jim's first commentary he took issue with my statements that the truth of any claim is an inference supported by evidence; that Truth it is not an entity in the world; and that truth is not a property possessed by true statements. In the book, I was attempting to explain why declaring that a claim "is true!" is not an argument for believing it. As Jim repeats his concern here, I must be missing some point he is making.

Before trying to address that point, let me clarify, that contrary to what Jim suggests, I do not assert that *the meaning* of a true statement is fully specified by the evidence for that statement. Being a child of late 20th psychology and influenced by Paul Meehl's notion of construct validity, I would not advocate for such a strong operationalist (or verificationist) perspective on meaning. Meehl's notion of construct validity referred to the meaning of theoretical terms such as depression (and was largely inspired by Rudolf Carnap's notion of partial definitions). Briefly, Meehl said that the meaning of theoretical terms such as depression cannot be fully specified by their observational consequences. They have surplus meaning by being implicitly defined by other theoretical terms – for depression that would include psychosis and psychiatric disorder.

On such Meehlian grounds, I also regard the pragmatist theory of meaning to be incomplete. The most often quoted definition of that theory is from Charles Peirce.

Consider what effects, that might conceivably have practical bearings, we conceive the object of our conception to have. Then, our conception of these effects is the whole of our conception of the object.

For instance, to say that something is hard is to say, if you scrape it with a sharp object, it will not scratch; if you throw it through a window, the window will break, and so on. These practical effects are important aspects of the meaning of hardness, but they are not the whole meaning. For example, we can discover a new practical effect such as if you bombard it with radiation, it will not be damaged. According to the strict operationalist, the meaning of hardness has changed with the inclusion of this new test. According to Meehl it has not changed significantly – the old observations and the surplus meaning are much the same.

Theoretical terms, theories, and statements are all different things, but any claim that one of them is true is typically going to depend on more than observation itself. I do not advocate for a dichotomy between strict operationalism (or verificationism) versus a transcendent, noumenal truth as Jim seems to suggest, nor would I occupy either end of a dimension with observation and transcendental truth as it end points.

Jim's final point is that people use words in many ways, and that our uses of metaphysical terms such as real, true, and objective may invoke essentialist standards or may invoke nominalist and non-essentialist standards I agree that the words are used in different ways and some people may be more Platonic and others more empiricist in how they use words such as real, true, and objective. This linguistic observation is one common insight behind the deflationist view that many metaphysical disputes are often verbal disputes.

However, I have typically adopted realist commitments about metaphysical claims involving the nominalist and non-essentialist features of empiricism. Consider biological species. Metaphysical disputes about whether the species category is a real category in nature are largely arguments about what one means by "real category," but some actual species concepts entail more than how words are used. One way of being a real category is for a biological species to share a fixed essence that is completely present in all members of the species (put there by God or by nature). In contrast, for Darwin a species is a population of individuals that varies, with no one feature or set of features that that all members must share. The properties may also change over time. A real species category can be thought of as a collection of individuals that form a homeostatic property cluster in Richard Boyd's sense or a real kind in John Stuart Mill's sense.

Verbal disputes seem inevitable once we introduce abstract terms like species, essence, and nature. However, the difference between the Platonic concept of species the Darwinian concept involves more than a matter of how we use words. It would take quite a bit of mental gymnastics to argue that both the Platonic and the Darwinian concepts of species are correct.

One of the most important considerations in adjudicating between the two is that the Darwinian concept of species readily coheres with and follows from the genetics of sexual reproduction, and the paleontological and biogeographical evidence. The Platonic concept preceded our understanding of this evidence and, historically, made it harder for us to see paleontological and biogeographical facts.

Platonic and empiricist commitments also have consequences that are more than linguistic and each offers range of advantages and disadvantages. One advantage of a universal human nature shared by all members of our species in the Platonic sense is it supports the notion of shared human rights. This is an attractive feature. Darwinian models have a more mixed record here, despite only being proposed after the Enlightenment. However, if combined with a theory of rights, the Darwinian model's emphasis on the continuity of species tends to broaden the theory to include animal rights to some degree.

One advantage of Darwinian non-essentialism is that differences are seen as variations, not deviations from an essential type. This supports tolerance in a different way than the Platonic concept does. Seeing difference rather than deviation is a better kind of tolerance, but complicated because accepting difference does not mean you tolerate everything no matter what. Tolerance is only meaningful in the context of norms and standards because what we "tolerate" is always a violation of some norm.

Concluding thoughts

Hopefully, I have explained myself and elaborated on what I wrote in the book without needlessly repeating ideas. Some of what I elaborated on here was itself a rethinking. This rethinking has been informative to me and maybe to others as well.

Like with much in philosophy, my overlong responses raise a question about whether such effort is worth it, or what contribution it makes. Some clues about my answer to that important question can be found in my repetition of nominalist themes. Essentialist thinking is easy to come by and difficult to leave behind. Learning to adopt a more non-essentialist (or nominalist) perspective can widen the scope of what we notice. Doing so takes practice. My responses illustrate how I practice it, and perhaps some readers might be encouraged to practice it as well.

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and conscientiously communicated to the public, the Goldwater Rule is itself morally problematic.

Since our paper came out, there have been articles and editorials about the Goldwater Rule in the *New York Times, Washington Post, CNN, Associated Press, Huffington Post*, fivethirtyone.com, *Vice News Tonight*, *Vanity Fair*, *Slate*, *Forbes*, *Psychology Today*, and *Rolling Stone*, among other popular publications. The psychiatric trade papers regularly address the propriety and scope of the Goldwater Rule. Citizen Therapists Against Trumpism published online Manifesto arguing that Trump's public behaviors and attitudes "is antithetical to the examined life and healthy relationships that psychotherapy helps people achieve." Three psychiatrists wrote a letter to President Obama in December 2016 explaining why Trump is psychologically unfit to serve as president. A change.org petition intended for the US Senate minority leader claimed that Trump is mentally ill and should be impeached under the 25th amendment. Two psychiatrists wrote to the *New York Times* that "We believe that the grave emotional instability indicated by Mr. Trump's speech and actions makes him incapable of serving safely as president."

Dr. Kroll and I are now working with members of the APA general assembly on an action paper to request that the Goldwater Rule be reconsidered for a variety of reasons. Disappointingly, the APA ethics committee reinforced the Goldwater Rule last week with little further consideration of the reasons for or against it. The opinion states that 1. Psychiatrists are ethically prohibited from evaluating individuals without permission or other authorization (such as a court order), 2. Psychiatric diagnosis without a full history and examination "compromises both the integrity of the psychiatrist and of the profession itself," and 3. Public diagnosis of a person a psychiatrist has never examined may stigmatize persons with mental illness, and make established patients wonder about the quality and confidentiality of their own treatment. This opinion is proffered with only superficial consideration of the arguments made against the Rule in the setting of last year's election, and it gives no substantive attention to its claim that expressing professional concerns about public figures creates or promotes stigma against persons with mental disorders generally. Dr. Kroll and I, with our APA colleagues, hope that by continuing to do good philosophy we can get the APA to do so, too.

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erations of coherence to inform what it means to be a fact. If so, the correspondence theory depends, in part, on the pragmatic and coherence theories.

I would argue, in contrast, that coherence actually depends on correspondence. Human history is replete with examples of this. Take, for instance, the diagnosis of Drapetomania in the 19th century. Psychiatrists concluded, in a coherent consensus, that run-away slaves suffered from Drapetomania. It was later determined that that coherentist conclusion was false. Thus coherence succumbed to correspondence. The coherentist might now respond, no, with more evidence the false conherentist conclusion was replaced by a correct coherentist conclusion. Now we come back to Peter's question, but in reverse. He says, "how do we know if what our statement corresponds to is indeed a fact?" But we can also ask: how do we ever know if our current coherence conclusion is any better that Drapetomania? I could now say that correspondence is always lurking in the background to judge coherence. Or, what I really think, that correspondence and coherence are inextricably entwined.

In his response to Cooper and Thornton, Peter discusses their objections to his apparent anti-realism, and specifically to his statement that "what Arthur Conan Doyle ate and drank on a particular day in 1903 was once a matter of fact, but is now not a fact because the information is not accessible to us…If we cannot access any information about what Doyle ate on that day, we cannot make factual assertions about that either. That is what I meant."

Let's switch the scene. My short-term memory is lousy, and consequently at the end of the day I often couldn't remember whether I took my morning pills. I fixed that problem a couple years ago by buying a pill box. At the end of, say, Monday, the Monday compartment was either empty or still contained the Monday pills. Before the fix, I had no way of determining whether I had taken the pills or not; with the pill box, I could answer the ques-

tion. About my situation before the pill box I think Peter would say: on Monday morning it was a matter of fact that you did or did not take the pills; but by Monday evening you were no longer able to make a "factual assertion" about whether you did or did not take the pills. And that means that on Monday evening the issue of your pill-taking on Monday morning is no longer a fact.

This does strike me as an unusual view on what makes something a fact. I would of course want to state it more simply: it was a factual matter whether I took the pills on Monday morning, and I will never know whether I did or not.

So far I have been talking about facts and evidence, correspondence and coherence in Peter's discussion of Rego, and the nature of fact in the discussion of Thornton and Cooper. In Peter's discussion of my own commentary, one of the issues is the status of truth, objectivity, the real, etc., and where they stand with respect to evidence. Around this issue Peter notes a commonality in the commentaries of Rego, Thornton, and myself. In my commentary I focus on how these words are used (and thus the reference to Wittgenstein). In the book Peter emphasizes that words like truth and objectivity, from an empiricist perspective, only have meaning when they imply, 'supported by evidence'. Otherwise they appeal to some kind of essentialist, transcendent standard that ignores evidence. If the discussion involves something like creationism, it's obvious that creationists are invoking some standard (e.g. religious belief in the Bible) other than scientific evidence. In many other areas this principle is less clear and depends on how the respective words are used – and that their use can veer from the essentialist to the nominalist. If I say, for instance, that the DSM represents an objective picture of psychopathology, I might be invoking an essentialist standard that implies that the DSM categories are based on essential features, or I might be merely saying that the categories are based on the best available evidence. In probably every case in which words such as true, objective, and real are used, we will have to determine what the speaker means in using them.

In this discussion, I may be making much of nothing. I am as nominalist and anti-essentialist as Peter, but I am arguing that concepts such as truth and reality may be Platonic, essentialist, and transcendent to experience, or they may not. I am arguing in a Wittgensteinian manner that the meaning of words is in their use, and that in their use these concepts cover a range from the essentialist to the nominalist.

JP

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