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By

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ABSTRACT

THE CONCEPT OF MENTAL DISORDER: A PRAGMATIC PROPOSAL

By

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Although seemingly straightforward, the concepts of health, disease, and illness are riddled with conceptual ambiguities, which have far-reaching ethical and practical implications. In recent years, philosophical analysis of the concepts of health, disease, and illness has focused largely on the identification of metaphysical markers that distinguish these concepts and make them recognizable as deviations appearing against a backdrop of normalcy. The distinction between naturalism and normativism is operational across what I call the 'standard theories' of health, disease and illness. This distinction turns on an assessment of the role of social values in defining health, disease and illness. Although I am sympathetic to naturalistic theories, I argue that they suffer from a number of limitations, which can be seen most clearly in the way they explain mental illnesses, and, specifically, personality disorders.

Personality disorders are particularly problematic because they are constellations of behaviors that seem to straddle the domains of mental illness and individual idiosyncrasy. In thinking about the ways to understand boundary cases of mental illness such as personality disorders, I argue that naturalistic theories are the best available to us, but fail because they depend on a concept of biological function and personality disorders are ultimately social dysfunctions. It is from this distinction that I begin my pragmatic line of argumentation by claiming that whether a particular state (social dysfunction) is properly called a 'disease' or 'disorder' is not a necessary condition of its being treated as

if it were one. In so doing, I augment naturalistic theories with reasonable pragmatic considerations, such that boundary cases might be justifiably treated as medical problems despite controversies regarding their biological basis.

In building this pragmatic theory, I focus on the case of borderline personality disorder. The theory I offer seeks to move beyond the metaphysical concerns that have captivated the standard theoreticians by focusing philosophical attention on the actual suffering of people affected by this personality disorder. As a form of pragmatic naturalism, my proposal rejects both metaphysical and epistemic foundationalism in favor of the empirical realities of personality disorders. Thus, as a dimension to this analysis, I will also suggest that personality disorders be understood in terms of the public health model, touching on ways to understand and mitigate the far-reaching effects of mental disorder on others in the community.

Any pragmatic model of mental disorder has a number of vulnerabilities. Most apparent is the fact that such a model will be open to abuse by those who wish to classify inconvenient, offensive, or immoral behaviors as mental illnesses. To answer these objections, I again employ the case of borderline personality disorder to offer an analysis motivated by social, political, and feminist philosophy to refine my theory. This analysis is crucial to developing an ethical pragmatic theory that enables an appraisal of what should count as a mental disorder—an appraisal that hopefully avoids the taint of political ideologies cleverly disguised in medical terms. I conclude with a brief discussion of potential policy ramifications presented by this pragmatic theoretical proposal.

For Corinne

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—Dominic A. Sisti, East Lansing, Michigan

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INTRODUCTION: TOWARD A PRAGMATIC THEORY OF MENTAL DISORDER

Although seemingly straightforward, the concepts of health, disease, and illness are riddled with conceptual ambiguities, which have far-reaching ethical and practical implications. Notwithstanding the ease with which physicians talk about the symptoms and cures of a particular disease or encourage patients to live a 'healthy' lifestyle, a moment's reflection reveals these interrelated concepts are both philosophically complex and exceptionally imprecise. If asked, most people would find it difficult to settle on a determinative statement about what counts as a disease and what it means to be healthy. Most would probably agree that breast cancer and HIV/AIDS are undoubtedly diseases. Others might raise their eyebrows when asked about attention-deficit hyperactivity disorder (ADHD) or restless leg syndrome.

Why the ambivalence? Are the concepts of health, disease, and disorder so amorphous that they are completely subjective? Is it possible to determine biological standards and an objective method for determining what constitutes health and disease? Should the concept of disease be limited to merely biological abnormalities? And, if so, who decides what is normal or abnormal? These questions suggest that the concepts of health and disease are moving targets—as they pass in and out of our conceptual sights, they become impossible to pin down.

As impossible as conceptual clarity may seem, for both biomedical ethics and medicine, the meanings of basic concepts so often employed must be constantly reexamined and clarified. This is true in any mature discipline. Legal theorists, for example, continue to debate basic concepts of jurisprudence and political philosophy. But just as there are sometimes profound consequences when philosophical concepts are

brought to bear in constitutional law, there are similarly far-reaching effects when the concepts of health and disease are critically examined or when they are haphazardly overlooked for the sake of expedience. Thus, in order to craft sound bioethical arguments, theories, and public policies it is first crucial that we clarify the most fundamental concepts of medicine.

As Edmund Pellegrino has suggested, "clarification of medicine's basic concepts is as much a moral as an intellectual obligation...confusion about the nature of health and disease is ultimately confusion about the concept of medicine itself."[1] I therefore present this dissertation as a contribution to the larger philosophical effort that seeks to clarify the concepts of health, disease, and illness with an eye toward practical solutions of problems in biomedical ethics and mental health policy.

In recent years, philosophical analysis of the concepts of health, disease, and illness has focused largely on the identification of metaphysical markers that distinguish these concepts and make them recognizable as deviations appearing against a backdrop of normalcy. As we will see, there is a basic distinction that is operational across what I call the 'standard theories' of health, disease and illness. This distinction, albeit packaged in various and diverse ways, turns on an assessment of the role of social values versus biological facts when defining health, disease and illness. As I will detail in the first chapter, there are two very broad categories of standard theories. According to standard naturalistic theories, the ontological reality of disease is explained in terms of biological function, and while values might play a role in defining disorders or illnesses, they are not determinative of disease. I will explain how normative features when applied to diseases may result in the ascription of 'illness.' Christopher Boorse has most notably

advanced this model.[2] In contrast, standard normative theories give social values a central and determinative place in nosology. For example, a normative model that focuses on the contextual features of function and dysfunction vis-à-vis the concepts health and disease has been articulated most clearly by H. Tristram Engelhardt.[3] To unpack these models, I will analyze the notions of biological function and dysfunction that serve as the foundation for theories that aspire to describe diseases as natural kinds. I hope to show how these models are generally superior to more normative or social models of disease when describing core cases of disease—things like cancer, infectious disease, and schizophrenia.

However, I will also acknowledge the problems of naturalistic theories, focusing on the ways in which the contemporary philosophers of medicine have conceptualized mental illness by surveying the landscape of theoretical models of mental illness. Notwithstanding vehement objections by antipsychiatry enthusiasts, I will argue that core cases of mental illness can be described according to the key markers proposed by naturalists. As an extension of a naturalistic theory, Jerome Wakefield's hybrid theory, which combines the notions of biological function and social values, is especially useful for describing core cases of mental illness. I will present the paradigm cases of schizophrenia and severe depression to illustrate the advantages of a hybrid theory such as Wakefield's.

As we will see, standard and hybrid theories suffer from a number of serious limitations, which can be seen most clearly in the way they handle personality disorders. Personality disorders are particularly problematic because they are constellations of behaviors that seem to straddle the domains of mental illness and individual idiosyncrasy.

For Wakefield, personality disorders are considered instances of mental illness even though they currently fail to meet the theoretical conditions of naturalistic foundations upon which his theory is based. Indeed, not only are the behavior patterns in question irreducible to markers of biological dysfunction but, also, they stand out particularly because they are defined exclusively in terms of social dysfunctions— as deviations from the expectations of a particular society or culture.[4]

I therefore will consider several preliminary questions: Should these behaviors be considered symptomatic of a mental illness or should they be considered instances of individual vice or moral failing? How might we distinguish their unique features to justify including them in our psychiatric nosology? What are some of the risks of further medicalizing such boundary cases of mental illness? To explore these and other questions, I will offer a multifaceted philosophical analysis of personality disorders that includes their sociological and political dimensions. I will eventually focus this critical analysis on borderline personality disorder.

In thinking about the ways to deal with boundary cases of mental illness such as personality disorders it seems there are four basic options. (1) We can decide to commit to one of the standard models and question the legitimacy of boundary cases as perhaps better described as 'problems of life' or behavioral idiosyncrasies that fall outside the purview of medicine. This is the option offered, for example, by anti-psychiatry advocates such as Thomas Szasz. (2) Alternatively, we can maintain a more optimistic naturalistic perspective, and envision a day when scientific research provides clear evidence of a biological dysfunction upon which to base our diagnosis of personality disorders. Wakefield seems to espouse such a speculative approach. (3) We might

question the conceptual basis of the naturalistic models and jettison those theories wholesale. Instead, we might ambitiously pursue an entirely new theory of mental illness that will more accurately capture our intuitions about boundary cases. Social constructionists, many of whom insist the concepts of health and disease are ultimately social contrivances, take this tack. (4) Or, finally, we might accept naturalistic theories as the best available to us, but then argue that whether a particular state is properly called a 'disease' is not a necessary condition of its being treated as if it were one. To do this we might augment naturalistic theories with reasonable pragmatic considerations, such that boundary cases might be justifiably treated as medical problems despite controversies regarding their biological basis. The ultimate goal of this dissertation is to pursue the fourth option.

Before I offer my own theory in chapters 4 and 5, it will be first important to explain why pursuing the other options is neither philosophically nor practically desirable. In short, the first and second options seem to dismiss without proper justification the causes of suffering that slip through the theoretical lacunae of the standard models. In chapter 2, I will describe the key shortcomings that limit the applicability of the standard models to instances of mental illness and the problematic consequences of these limitations. I will look carefully at Boorse's theory and Wakefield's hybrid model of mental illness and show why their theories, by design, fail to adequately explain the reality of personality disorders. From the other pole of the debate, I will describe the positions of social constructionists and anti-psychiatry theorists, who insist the notion that mental disorder is anything but a socially determined contrivance.

The third option presents us with the opportunity to develop an entirely new theoretical framework for the concepts of mental health, disease, and illness. Because this strategy is based largely on a social model of health and disease, which eschews the objective nature of core cases of disease and disability, it leads to counterintuitive conclusions. This option also seems impractical, particularly because it ignores the significant work and progress made by theoreticians who have described the reality of core cases of disease and illness, simply because their work has not been perfect in addressing boundary cases. But building a new theoretical framework from the starting point of boundary cases is not prudent. Just as hard cases make bad law, boundary cases of illness would make bad nosological theories and would sacrifice what I believe could be an adequate theory in search of a perfect one.

Therefore, we are left with what I argue is the most parsimonious and promising option—developing a pragmatic model of boundary cases of mental illness that augments and complements the standard naturalistic models. Although I will draw upon the work of philosophy and psychology of Pragmatists William James and John Dewey, my proposal should be characterized as pragmatic in the colloquial sense. The basic goal of this theory is rather straightforward: identifying constellations of behaviors that cause suffering and trying to figure out how to minimize that suffering. In one sense, the pragmatic theory I will offer might be characterized, like Wakefield's, as a hybrid theory because it starts from a set of naturalistic premises about the nature of disease and builds out from there. However, it is not genuinely naturalistic because the pragmatic adjunct to this theory is wholly determined by particular social values. As I will detail, I have no expectation that biological markers or correlates will ever be discovered, nor need be discovered, for

personality disorders and other boundary cases to be correctly considered legitimate mental illnesses. Social dysfunction is enough, according to this approach, to establish a constellation of behaviors as a mental illness. I will preview my own theory by synthesizing two other pragmatic theories in chapter 3.

The pragmatic model I will offer seeks to move beyond the metaphysical concerns that have captivated the standard theoreticians by focusing philosophical attention on the actual suffering of people affected by personality disorders. Thus, as a form of pragmatic naturalism, my proposal rejects both metaphysical and epistemic foundationalism in favor of the empirical realities as people in the world experience them.[5] Thus, I will offer a phenomenology of personality disorders to support one of the key facets of my overall argument: that personality disorders should count as mental illnesses particularly because of the actual, palpable suffering they cause patients, family members, and the larger community. Of course, many things cause suffering and are not considered illnesses. So I will explain why I think the specific kind of suffering experienced by people affected by personality disorders falls within the scope of medical expertise and is deserving of medical attention. As a dimension to this analysis, I will also suggest that personality disorders be understood in terms of the public health model, touching on ways to understand and mitigate the far-reaching effects of mental disorder on the community.

Any pragmatic model of mental disorder has a number of significant vulnerabilities. Most apparent is the fact that such a model will be open to abuse by those who wish to classify what they consider to be inconvenient, offensive, or immoral behaviors as mental illnesses. Therefore, in chapters 5 through 7, I will offer a critical

analysis motivated by scholarship in social, political, and feminist philosophy to help refine my theory. This analysis will prove crucial to developing an *ethical* pragmatic theory that enables an appraisal of what should count as a mental disorder—an appraisal that hopefully avoids the taint of political ideologies cleverly disguised in medical terms. Again, as a case study, I will turn to the borderline personality disorder. Uncovering the social and political biases that historically motivated the diagnostic criteria for borderline allows us to more carefully parse the expectations and values implicit in the current DSM framing of personality disorders. Similarly, the cycle of medicalization and demedicalization of homosexuality will serve as an example of how certain behaviors, which merely deviate from mainstream or traditional mores, have been unjustifiably classified as diseases.

As I discuss these examples, it will be important to note that although, in some cases, the reification of behaviors as 'disorders' might have been caused by ulterior political motives, this does not necessarily mean that categorization of those behaviors is unnecessary or inappropriate today. On the contrary, an understanding of the intentions of the agents of medicalization (e.g. pharmaceutical companies, professional institutions such as the APA, advocacy groups such as the National Alliance on Mental Illness) is only one part of the larger analysis. I hope to show that in the case of borderline personality disorder, gender bias had largely motivated the definition and expansion of what I describe as the standard construction of the diagnostic category.

Today, however, we are hopefully equipped with a more sophisticated understanding of borderline personality disorder that recognizes its problematic history yet acknowledges it as a serious psychological problem. The therapeutic goal of

medicine—rooted in the authentically beneficent desire to relieve the suffering of patients—can and should now supersede these more base political intentions and further motivate research and enhanced access to therapy for personality disorders such as borderline. Thus, the historical account provides us with an anti-paradigm, which offers a cautionary note about the moral hazards of expanding a psychological category based on merely pragmatic, albeit unethical, considerations.

Finally, in developing a pragmatic theory of mental disorder, I hope this dissertation will offer a compelling set of arguments for use by patients and families who are affected by personality disorders and who seek recognition and help. Though it should be expected that any pragmatic theory would necessarily aim for real social change, I should state openly that my motivation for writing this dissertation is both philosophical and political. By marshalling the strongest philosophical arguments about the troubling reality of mental illness and particularly of boundary cases, I hope to advance the cause of those who seek mental health care parity in a deeply polarized and largely unsympathetic political environment. Ways to actualize these political aspirations will be suggested in chapter 8.

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1. Edmund D. Pellegrino, "Foreword: Renewing Medicine's Basic Concepts," in *Health, Disease, and Illness: Concepts in Medicine*, ed. Arthur L. Caplan, James J. McCartney, and Dominic A. Sisti (Washington DC: Georgetown University Press, 2004), xii.

2. Christopher Boorse, "On the Distinction Between Disease and Illness," in *The Concepts of Health and Disease*, ed. Arthur L. Caplan, H. Tristram Engelhardt, Jr., and James J. McCartney (Reading, MA: Addison-Wesley, 1981), 545-560.

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4. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text rev. (Washington, DC: American Psychiatric Association, 2000).

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CHAPTER 1

THE CONCEPTUAL LANDSCAPE OF THE CONCEPTS OF MENTAL HEALTH, DISEASE, & ILLNESS

Introduction

Over the past several decades, the list of terms used to describe theories of health, disease and illness has become quite expansive.[1] Various scholars have defined these concepts in terms of fundamental metaphysical commitments (e.g. essentialist vs. nominalist), the influence of social values (e.g. the medical vs. social models of disability), and the locus and cause of the disease in question (e.g. xenochtonous vs. autochtonous). Several theories of health and disease delineate between epistemic (e.g. *deduktiv* vs. *empiristisch*) and linguistic variations (e.g. natural kind semantics vs. descriptive semantics) of the concepts.[2] This wide array of terms used to denote the concepts of health, disease, and illness has led some to suggest that the debate about the ontology of these concepts is now confused and will remain irresolvable without serious clarification of theoretical assumptions.[3]

In this dissertation, I will distinguish between the various explanations of the concepts of health, disease, and illness by using two very broad categories, which reflect the lines of debate about the ontology of disease and illness as being roughly drawn between naturalistic theories or normative theories. Simply put, nosological naturalists contend that disease can be understood according to objective biological markers and that diseases are caused by real entities or phenomena. Diseases and derivative illnesses are biologically based. Generally, naturalists consider diseases to be natural kinds. Much like the planets or chemical elements, naturalists contend diseases exist in nature and are

independent of human experience, interpretation, or contrivance. In contrast, normativists argue that social values play a critical role in any theory of health, disease, and illness and they eschew scientific positivism. In particular, strong normativists argue that it is impossible to disentangle social norms and values from even the most basic concept of disease. A third kind of theoretical approach seeks to hybridize the naturalist intuitions about the biological reality of health, disease, and illness while simultaneously recognizing the role values play particularly in defining 'illness' and 'disorder'.[4] I will be discussing the distinction drawn by these theoreticians between the concepts of disease and illness.

I am choosing to delineate between naturalism and normativism because they provide the broadest swath of theoretical landscape against which to later frame a pragmatic theory of mental illness. In this chapter, I will first present a survey of naturalism and normativism alongside influential hybrid theories. I will then focus on specific critiques of naturalism in mental illness by describing insights from social constructionists such as Michel Foucault and Thomas Szasz. The goal of this chapter is to provide the reader with a basic background on theories of health, disease and illness in preparation for detailing the specific problem of how, where, and why personality disorders might fit into a pragmatic theory of mental illness. Let us begin with nosological naturalism.

Naturalism

Naturalism locates its historical roots in the ancient theories of Hippocrates & Galen, who considered diseases to be necessarily constituted by imbalances in the four

humors: black and yellow bile, phlegm, and blood. The humoral theory of disease persisted for centuries through the Middle Ages, when Paracelsus described the cause of disease as imbalances in the body's three essential substances (salt, mercury, and sulfur), which resulted from autonomous entities "springing from the body." Centuries later, the modern concepts of health and disease, as with the practice of scientific medicine itself, became dependent on Cartesian mechanistic reductionism and mind/body dualism. So-called ontologists such as Fracastorius (1546), Thomas Sydenham (1670) and 19th century polymath, Rudolf Virchow, located the cause of disease and epidemic not in internal imbalances but rather discrete causal agents (spores, miasma or *ens morbi)* that entered the body.[5]

Contemporary naturalists have moved well beyond the theories of the early humoralists and ontologists. Today they ground their nosological theories about the objective reality of disease on a sophisticated understanding of evolutionary biology and genetics. Christopher Boorse has developed and defended the most sophisticated contemporary version nosological naturalism. Boorse claims that the concept of disease is grounded in the "autonomous framework of medical theory, a body of doctrine that describes the functioning of a healthy body, classifies various deviations from such functioning as diseases...This theoretical corpus looks in every way continuous with theory in biology and other natural sciences, and [is] value-free."[6] As such, Boorse argues that diseases are recognizable against the objective backdrop of species typical function—a concept he borrowed and refined from J.G. Scadding.[7] Thus, the epistemic core of Boorse's theory of disease is statistical— determining species typicality is a completely empirical question. Boorse has labeled his particular brand of naturalism the

"biostatistical theory."[8] Disease is defined by Boorse as "a type of internal state which is either an impairment of normal functional ability, i.e. a reduction of one or more functional abilities below typical efficiency, or a limitation on functional ability caused by environmental agents."[9]

In his early writings, Boorse had drawn a gross distinction between the concepts of disease and illness. He defined the concept of illness as a subclass of disease: those diseases that carry with them "certain normative features reflected in the instructions of medical practice" are considered illnesses.[10] To support this framework and to show that disease is value-free, Boorse pointed out that we do not claim that plants or animals can be ill or suffer from an illness. Rather we describe plants and animals as simply being diseased. Secondly, Boorse recognized that the ascription of illness grants the sufferer "special treatment and diminished moral accountability."[11] Thus, illness is a morally laden concept, while the concept of disease is completely amoral. According to Boorse (1975),

> A disease is an illness only if it is serious enough to be incapacitating, and therefore is: (1) undesirable for its bearers; (2) a title to special treatment; and (3) a valid excuse for normally criticizable behavior.[12]

In his more recent writings, Boorse has refined the simple distinction between a value-free disease and a value-laden illness, noting in part that his semantic justification was flawed. The term 'illness' is in fact semantically similar to 'sick' and both are terms used to describe the state of human and nonhuman organisms. Boorse has expanded the simpler notion of illness to include a range of grades of health, which capture the various normative dimensions of illness.

Accordingly, like disease, the theoretical concept of health should be considered to be amoral. To determine an individual as healthy is to assess an individual's function in comparison to the rest of their species. Species-typical functioning is, at base, what grounds Boorse's theory of health and disease. Health is thereby presumed to be the capacity of organisms to achieve evolutionarily determined goals (i.e. survive, reproduce, enhance fitness through kin selection, etc.). Boorse recognizes that the concept of health is also culturally and socially determined. Depending on the context, the word 'health' might correspond to the opposite of illness— that is, 'health' could refer to a state that is desirable entirely because of social norms. An example of the strongly normative definition of health is that of the World Health Organization: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[13] Boorse claims that the theoretical concept of health, because it is often confused with more practical and colloquial usage, makes it unnecessarily ambiguous. For Boorse, determining the theoretical definition of health is his central philosophical goal, which he claims to achieve through the evolutionarily based concepts of species function and disease, both of which are value-free. Therefore, "the medical conception of health as absence of disease is a value-free theoretical notion."[14]

Strong Normativism

Scholars in the philosophy, sociology, and history of science and medicine have challenged Boorse's naturalistic theory of disease and illness. Despite his compelling account, they argue, the history of medicine is rife with examples of value-laden concepts of diseases. We need only recall the antebellum disease called drapetomania (i.e. the

tendency of slaves to run away), the medicalization of premenstrual syndrome, menopause, and masturbation.[15] In each of these cases, particular 'biological dysfunctions' were supposedly identified and determined to be the root cause of the disorders in question. In the case of drapetomania, slaves were said to have a biologically based tendency to abscond, which was directly related to physiological features such the color of "the negro's brain and nerves, the chyle and all the humors, [which] are tinctured with a shade of the pervading blackness."[16] The process of medicalization of both PMS and menopause arguably revealed particular gendered assumptions about the proper role of women in society and within the family; assumptions that I will more fully articulate with my examination of the borderline personality disorder. As we will see in cases of personality disorders, such as borderline, we find marked deficiencies in the functional status of a stable, rational, and unified concept of the self as idealized by Kant. The assumption that the female self is unstable has also served as the basis for the invention of other mental illnesses like kleptomania by offering a way to explain deviant behavior by well-to-do middle-class women.[17] The upshot, feminist philosophers argue, is that psychiatric categories place women in a double bind, where attaining health is only possible through deference to (male) authority and a medical diagnosis is bestowed upon those women who do not conform.[18]

Along similar lines, disability scholars have clarified the distinction between the social and biological models of disability. Activist scholars reject naturalistic accounts of disability, claiming instead that disability is a social construction that marginalizes people whose bodies or minds do not meet the standards of the status quo. They claim the biomedical model of disability is so pervasive it has led to what Amundson calls the

standard view: the idea that being disabled is a biological deficiency that is obviously bad for one's quality of life.[19] This view is also entrenched in philosophical literature on quality of life. Interestingly, however, empirical evidence has exposed the paralogism of the standard view: disabled people feel their quality of life is only slightly less than nondisabled people, and it is much higher than what nondisabled people would have ever guessed.

This revelation lends credence to the social constructionists' call for accommodation and acceptance of the full range of human ability. Their basic objection to naturalism is that species typical function is an irrelevant determination since variation— even in instances of statistical outliers— is an essential part of a species' evolutionary history. Statistical curves might describe the numbers of individuals with a particular trait, but do not capture the importance of the diversity within those traits. Additionally, the cut-off points of typicality and normalcy are completely arbitrary and rooted in social ideals about types of bodies and minds.

Although below I will describe H. Tristram Engelhardt as moderate normativist, his early theory, described in an influential series of articles and lectures, reveals the markings of an unabashed strong normativist. In one of his most well known articles, Engelhardt draws on the historical and sociological construction of the "disease" of masturbation to argue that the concept of disease is ultimately value-laden.[20] He argues that diseases, whether somatic or psychological, are not objectively determinable biological states but, instead, always include an important moral dimension. In Engelhardt's words,

> ...although vice and virtue are not equivalent to disease and health, they bear a direct relation to these concepts. Insofar as a vice is taken to be a deviation from an ideal of human perfection, or "well-being," it can be translated into disease language...This shift is from an explicitly ethical language to a language of natural teleology. A 'disease entity' operates as a conceptual form organizing phenomena in a fashion deemed useful for certain goals. The goals, though, involve choice by man and are not objective facts, data 'given' by nature. They are ideals imputed to nature. The disease of masturbation is an eloquent example of the role of evaluation in explanation and the structure values give to our picture of reality.

As we will see, there is no shortage of disturbing examples of the medicalization of (im)morality or social deviance. From race and gender to sexuality and disability, it is arguably possible that any power structure in society can be reinforced or expanded through the process of medicalization. Thus, a key problem for my pragmatic theory will be distinguishing between instances of nefarious medicalization and arguably ethical instances of medicalization—defined in terms of benefit to patients, families, and the community. For now, the important point is that the above examples of medicalization are often presented as paradigm cases in support of normativism and, as such, are used to argue strongly that it is impossible to create a nosology that is not inherently normative, political, or otherwise socially influenced.

An important question now emerges: Do these examples of socially constructed diseases offer convincing evidence that the concepts of health, disease, and illness are

value-laden? One could reasonably argue that these cases of medicalization do not provide enough evidence that diseases are a wholly value-laden or socially constructed. Rather, these "diseases" are simply cases in which a correct objective concept of disease was misused or abused. Ironically, many of the cases used by strong normativists seem to actually support the naturalist position, since the recognition of pseudodiseases presupposes the existence of an objective set of criteria that expose the absurdity of "diseases" like drapetomania.[21] This is to say that without the objective facts of biology, anything could be construed as a disease. And the scientific "facts" were simply false in the egregious cases cited by strong normativists. In his rebuttal, Boorse makes exactly this point. He says, "Engelhardt's essay shows that if we abstract, as he does, from all questions of truth and falsity, then masturbation and drapetomania were Victorian diseases. Equally, if we abstract from all questions of truth and falsity, then cows jump over the moon." [22]

Additionally, strong normativists who rely exclusively on historical examples seem to rely heavily on the important insights of Ludwig Fleck and Thomas Kuhn, both of whom argued that social values permeate all of science rendering the entire enterprise politically driven. In so doing, proponents of this strain of strong normativism fall prey to a sort of genetic fallacy by claiming that because the social structures of science and medicine are riddled with social and political values, the products of those enterprises (such as nosologies) must also be merely social and political artifacts. As such, these products carry with them the social values of a particular group of researchers and may influence or conflict with the views of other factions. Engelhardt articulates this point stating,

> ...as the history of medicine has shown, medicine's explanatory goals are pursued by particular groups of scientists with particular understandings of what should count as the proper rules of evidence and inference, which may conflict with lay understandings of disease and treatments or the understandings of other investigators. To resolve such controversies, those involved will need to make clear what the rules of evidence out to be accepted and why.[23]

Although, as I have mentioned, there are limits to the logic of using historical cases as evidence of the true ontology of disease, Engelhardt's insight will become important when we discuss the pragmatic theory of mental illness, which I will frame as an overtly normative extension of naturalist theories of mental illness. In order to construct an ethical pragmatic theory of mental illness we will need to describe how to handle the latent values that might drive scientific research for good or for ill, and make transparent our pragmatic goals about why and how categorizing personality disorders occurs.

In contrast to appeals to historical and sociological evidence, other normativists like Peter Sedgwick take a more metaphysical tack by arguing that disease and illness are, quite simply, not natural kinds. Sedgwick claims,

> There are no illnesses or diseases in nature... The fracture of a septuagenarian's femur has, within the world of nature, no more significance than the snapping of an autumn leaf from its twig; and the invasion of a human organism by cholera-germs carries with it no more the stamp of "illness" than does the souring of milk by other forms of bacteria.[24]

Here Sedgwick draws upon a basic fact/value distinction to argue that the only reason diseases matter is because of their impact on human needs and desires. Boorse, however, would quickly respond by contending that a broken femur is a disease—apart from its impact on human desire—simply because it impairs the functioning of the leg, which likewise impairs the function of the individual.

A couple other strong normativists are worth mentioning by way of introduction. Caroline Whitbeck has argued that diseases are not value-neutral, but are the result of a frustration of what people expect to be able to do in a particular culture. Thus, those states that constitute diseases "depend on a value judgment of the societal group, *rather than* upon either the judgment of the person afflicted or simply the judgment of the professional whom the society has charged with developing and applying therapeutic measures."[25] In a similar way, George Agich rejects Boorsian naturalism. He claims that disease is value-laden insofar as disease constitutes a limitation on the sufferer's freedom. For Agich, disease is not simply a biological fact, but rather a socially embedded and complex limitation of personal freedom.[26] Agich's pragmatic theory of illness will supply a starting point for my own pragmatic model of mental disorder.

In the end, strong normativism, whether it is based on historical and sociological study or on the careful clarification of philosophical distinctions, seems to remain vulnerable to Boorse's arguments and counterarguments. Perhaps more moderate forms of normativism, which grant the existence of brute facts of nature while also recognizing the permeation of values in assessing those facts, will provide a more convincing framework to satisfy the common intuition that health, disease, and illness are in some way value-laden concepts.

Moderate Normativism & Hybrid Theories of Disorder

Between the strong normativist and naturalist positions lies an ensemble of moderate normativist and hybrid positions. In his more recent writings, Engelhardt, while rejecting Boorsian naturalism completely, offers a more moderate normative theory of disease and illness. He clearly recognizes the roles played by social values, religion, and law in constructing medical realities such as diseases. These roles are reflected in the so-called 'four languages' of medicine that demarcate the domains of discourse and reality within which medicine operates. The first of these languages deals with "evaluative assumptions regarding which functions, pains, and deformities are normal in the sense of proper and acceptable."[27] Engelhardt vigorously argues that assessments of dysfunction or species typicality are highly problematic because they fail to account for a variety of important evolutionary concerns such as species diversity and inclusive fitness. He accepts Boorse's naturalism as well suited for the unapplied biological sciences such as zoology, but claims it is woefully inadequate for medicine, which aims toward particular goals determined by physicians, patients and society.

Other forms of moderate normativism take a different tack by describing diseases in terms of disorders in the integrity of the body or mind that inhibit so-called prudential functions (i.e., those things that matter to attaining prudential values such as the avoidance of pain, death, and security) or that diminish a person's ability to achieve vital goals.[28] For Clouser, Culver, and Gert what makes a disease or injury a unique kind (or malady) is that there is an undesirable abnormality— defined in both natural and social terms— that exists without a distinct sustaining cause. On this model, a disease is one

kind of malady, existing alongside traumatic injury, lesions and other defects.[29] All diseases are maladies but maladies are not necessarily diseases. Examples of nondisease maladies would include injuries or other evils that lack distinct sustaining causes. Simply put, a disease is a species within the genus malady. Although Clouser, Culver, and Gert claim that their concept "considerably lessens the influence of ideologies, politics, and self-serving goals in manipulating malady labels" they do admit to its vagueness.[30] I consider malady to be a hybrid theory of disease because "it can be universal and objective and at the same time have values as an integral part."[31]

Jerome Wakefield has developed a moderate form of naturalism in his influential hybrid theory of mental illness.[32] Wakefield has tried, in his own ambitious words, "to construct a more adequate analysis and to resolve the fact/value debate" vis-à-vis the concepts of health and disease.[33] To do this, Wakefield offers his two-part concept of harmful dysfunction used to determine a disorder. He begins by describing function in a very specific medical sense:

> Function and dysfunction in the medical sense refer, in the first instance, not to the quality of a person's performance in a given environment but to whether mechanisms within the person are performing or failing to perform functions they were designed to perform.[34]

Similarly to Boorse, Wakefield goes on to argue that biological functions are completely value neutral, while the degree to which these dysfunctions are harmful include normative and value-based judgments. Once a dysfunction is considered harmful, it is called a 'disorder'. In other words, healthy cells, tissues, organs, and systems perform a function determined by evolution, which when disrupted and determined to harmful, can

be described as a disorder. Evolutionary biology determines function or dysfunction, while social values and norms determine if an instance of dysfunction is harmful or not. Wakefield uses the term *internal mechanisms* to refer to both physical structures and organs and mental structures and dispositions. Wakefield therefore sets out to describe a unified concept of disorder- one that will be equally applicable for understanding both mental disorder and physical disorder.

To construct the concept of disorder, Wakefield first provides a detailed description of how a determination of dysfunction can be derived from evolutionary theory. Essentially a mechanism's usefulness toward the goal of survival and reproduction of an organism—or enhancing an organism's inclusive fitness—determines that mechanism's natural function:

> In brief, those mechanisms that happened to have effects on past organs that contributed to the organisms' reproductive success over enough generations increased in frequency and hence were 'naturally selected' and exist in today's organisms.[35]

It is important to recognize an organ has many effects, but, according to Wakefield, only one function. Although the heart makes a sound when beating, its function is to pump blood, not create sound. His theory of function must be robust enough to distinguish between the miscellaneous effects of organs and their teleologically defined function. Wakefield claims the biological sciences give us the methods and tools to ascertain function and draw this distinction. Wakefield defines natural function as "an effect of the organ or mechanism that enters into an explanation of the existence, structure, or activity of the organ or mechanism."[36] To the extent that function and dysfunction are purely

scientific assessments, such assessments are enhanced and sharpened with technological advances. At present, Wakefield thinks we have a substantial understanding of natural function based on our knowledge of anatomy, physiology, and genetics. However in the context of mental disorders, Wakefield acknowledges that our knowledge of mental mechanisms is too deficient at present to clearly demarcate biological dysfunction. He says,

> this ignorance about the detailed nature and causal histories of mental mechanisms...makes it...necessary to rely on functional explanations based on inferences about what mental mechanisms are probably designed to do. In this respect, we are now at a stage of understanding that is comparable in some ways to the position of ancient physicians who had to rely on similar inferences in judging physical disorder...as we learn more about the naturally selected functions of mental mechanisms, our judgments about dysfunctions will become correspondingly more confident.[37]

As we will see, Wakefield's speculation that our dearth of scientific information on the etiology of mental illness will eventually be resolved is one of the most problematic aspects of his theory that the pragmatic theory I develop will try to address.

The second part of Wakefield's theory entails a description of harm. He acknowledges that it is tempting to justify a concept of disorder on simply dysfunction, thus fulfilling the nonnormativist aspiration for a value-free framework of disease and disorder. Wakefield understands this as impossible; he explains that a dysfunction must cause harm to a person and, admittedly, this harm might be based on cultural standards of

what is valued or disvalued. Likewise, the harm requirement might not be met for certain dysfunctions, thereby exempting them from disorder status. For example, the harm requirement explains why "albinism, reversal of heart position, and fused toes are not considered disorders even though each results from a breakdown in the way some mechanism is designed to function."[38]

In contrast to the theories presented above, Marc Ereshefsky claims that conceptual consensus is impossible because normativism, naturalism, and hybrid models are all ultimately incoherent and the current debate is not productive.[39] He suggests jettisoning the normativism-naturalism distinction altogether and looks instead to so-called state descriptions (objective physiological measurements) and corresponding normative claims (a claim that the state is good or bad for a person). State descriptions differ from descriptions of function in that they are empirical reports of current conditions that avoid appeals to concepts of 'natural' or 'normal'. Moreover, state descriptions have nothing to say about whether the state in question is either functional or dysfunctional. According to Ereshefsky, instead of defining health and disease as natural kinds or normative constructions, state descriptions provide more conceptual promise because they pinpoint the phenomena in question. A normative assessment then provides an account of whether it is valuable or not. This method is advantageous because, as Ereshefsky claims, state descriptions aim to avoid overt normative claims about normalcy. Moreover,

> ...there are three reasons for using the distinction between state descriptions and normative claims. First, talking in terms of state descriptions and normative claims clarifies discussions of controversial

> medical cases. Second, by framing debates in such terms we get to the issues that matter in medical discussions, thus rendering the terms 'health' and 'disease' superfluous in such discussions. Third, using the distinction between state descriptions and normative claims avoids the problems facing the major approaches to defining 'health' and 'disease'.[40]

Ereshefsky's point makes intuitive sense. By shifting attention away from theories that are dependent on more fundamental metaphysical distinctions, Ereshefsky has indicated he wishes to focus on the particular conditions in question. This is a promising start toward a more pragmatic theory of health, disease, and illness. However, Ereshefsky points to the possibility of ascertaining and disentangling the objective reality of particular states from normative claims pertaining to those states. And while Ereshefsky argues that his proposal advances the debate beyond the traditional lines of naturalism and normativism, the distinction between state descriptions and normative claims will ultimately become confused because, as he admits,

> Many state descriptions in the medical and biological sciences undoubtedly rely on implicit normative assumptions...State descriptions, contain no explicit normative components. By using the distinction between state descriptions and normative claims we make normative assumptions as obvious as possible. Once values are seen as entering a discussion, any talk of values is highlighted as a 'normative claim': that way, discussions concerning values will be explicitly normative. State descriptions will never be completely value-neutral, but we can do our best to label value judgments as such when they are identified.[41]

And although Ereshefsky wishes to shine a light on the implicit values of our conceptual claim about disease and dysfunction, we nonetheless seem to be back to square one: an attempt to distinguish between objective facts and social values that has come to define the tension surrounding the core concepts of medicine.

In any case, I will argue that for mental illnesses—and particularly personality disorders—Ereshefsky is on to something important and that his call for normative transparency, much like Engelhardt's, is correct. In describing my pragmatic model of mental disorder, I hope to provide a set of key ethical considerations that will add relief to the normative assumptions being made about a particular set of questionable behaviors. Insofar as personality disorders *qua* constellations of particular behaviors constitute state descriptions, Ereshefsky's theoretical background is helpful. In the meantime, let us continue our survey of the conceptual landscape of mental illness, particularly related to theories that are deeply skeptical mental illnesses exist at all.

The Social Construction of Mental Illness & Anti-Psychiatry

Notwithstanding the promise of hybrid theories of disease and disorder, the ongoing debate between normativism and naturalism continues and is most obvious in psychiatry. Several theories of illness posit that cases of what we now consider to be mental illnesses are purely social constructions and have no necessary basis in biological dysfunction. One important strain of social constructionism is exemplified by the complementary writings of Georges Canguilhem and his student Michel Foucault.

In his influential work, *Le Normal et le Pathologique*, Canguilhem laid the foundation for understanding the distinctions grounding the practice of medicine are borne out of the latent values of the structures of science, particularly in attempts toward

a definition of normal through experimental work in physiology. While his core set of arguments target Claude Bernard's experimental naturalism, Canguilhem seems also to anticipate the development of Boorse's philosophical naturalism, which will arrive within two decades. As cited by Tiles, Canguilhem offers the following prescient insight:

> If it is true that the human body is in one sense a product of social activity, it is not absurd to assume that the constancy of certain traits, revealed by an average, depends on the conscious or unconscious fidelity to certain norms of life. Consequently, in the human species, statistical frequency expresses not only vital, but also social normativity. A human trait would not be normal because frequent, but frequent because normal, that is, normative in one given kind of life, taking these words 'kind of life' in the sense given to them by human geographers. [42]

In essence, Canguilhem argues that normalcy is impossible to define on strictly scientific or statistical bases. Expressions of normalcy—even the most ostensibly objective biological expressions—always include values imparted from social structures and ways of life. This perspective comes from Canguilhem's unique medical epistemology, in which both empirical science (experimental medicine) and rationalism are inextricably linked aspects of medicine. Thus, for Canguilhem, the concepts of health and disease are not sufficiently explained in terms of mathematical or statistical data. Rather, health, disease and normalcy are all comprised of an organism's capacity for adaptability and capacity to flourish. They are qualitative and interdependent concepts.[43]

Canguilhem's work set the stage for Foucault's genealogical analysis of madness, which aimed to expose the power and social dynamics from which particular forms of

mental illness were objectified. In *Madness and Civilization,* Foucault presents a historical-philosophical portrait of the developments that led to the cultural construction of mental illness, as we now understand it. He argues that through a series of exclusionary institutions (e.g. the ship of fools and the so-called "Great Confinement" of lunatics in Parisian asylums), madness took the place of leprosy and other socio-medical blights. The justification for exclusion and confinement no longer came from the symptoms of leprosy but from the characteristic "Unreason" of the madman, which became recognizable only after the Enlightenment standard of reason had been firmly established:

> It is not on this horizon of *nature* that the seventeenth and eighteenth centuries recognized madness, but against a background of *Unreason*; madness did not disclose a mechanism, but revealed a liberty raging in the monstrous forms of animality. We no longer understand unreason today, except in its epithetic form: the *Unreasonable*...For classical man, madness was not the natural condition, the human and psychological root of unreason; it was only unreason's empirical form.[44]

In fact, the central themes presented in *Madness and Civilization* seem to be a reflection of Foucault's doctoral research on Kant's *Anthropology from a Pragmatic Point of View*. In *Anthropology*, Kant sets out a very crude (by today's standards) empirically based psychological nosology in which he distinguishes between very broad categories of mental illness such as melancholia and derangement. And it should come as little surprise that Kant's nosology relies upon an assessment a person's capacity for correct reasoning.

In his *Introduction to Anthropology,* which was a complementary thesis written alongside *Madness and Civilization*, Foucault recognizes Kant's central point in *Anthropology* that "man is neither a *homo natura*, nor a purely free subject; he is caught by the syntheses already operated by his relationship to the world."[45] This intermediary position of mental illness- residing somewhere between a natural and an artificial kind- which, according to Foucault, is articulated by the most paradigmatic of Enlightenment thinkers should give us pause in efforts to strictly define mental illness in purely naturalist or purely normativist terms. Though it is widely believed that Kant rejects the promise of both rational (i.e. metaphysics) and empirical psychology to answer his core philosophical questions such as "What is the Human Being?" and its corollaries concerning idiosyncrasies of the human mind, he does recognize the practical value of categorizing particular behaviors according to pragmatic concerns.[46] I should note that the intellectual thread that begins with Kant's pragmatic anthropology of mental illness runs through (and has to some degree inspired) the pragmatic theory of mental disorders I will soon present.

In a continuation of Foucault's reporting of "The Great Confinement" and thesis that mental illness supplanted leprosy, Thomas Szasz similarly argues that the concept of mental illness locates its roots in witchcraft, eventually superseding witchcraft as a scientifically 'valid' version of it.[47] This thesis is clearly articulated in Szasz's 1970 book, *The Manufacture of Madness,* in which he argues that institutional psychiatry- that branch of psychiatry that facilitates the involuntarily commitment of mentally ill patients- is nothing more than a modern day version of the Inquisition. As is well known, in his seminal book, *The Myth of Mental Illness,* Szasz describes mental illness as nothing more

than metaphor or an artifact of language.[48] As a result, he argues that both the insanity defense and forced incarceration are nothing more than devices used to either exculpate bad behavior or violate individual liberty.

Szasz's decades-long refusal to recognize a natural reality of mental illness is an example of strong normativism or social constructionism in psychiatry. But by the same token, by claiming what are conventionally considered mental illnesses are reducible to somatic disease, Szasz is really a strict naturalist for disease more generally.[49] We will return to Szasz when we consider the blameworthiness of patients with personality disorders and whether they suffer from mental illness or are simply vicious. We will also address Szaszian objections to pragmatically motivated ascriptions of mental disorder. Suffice it to say, Szasz's libertarian critique of modern psychiatry has provoked heated debate within mainstream psychiatry and among the lay public about overreach in the medicalization of human behavior.

With that in mind, I should note here that both Foucault's archeology of madness and Szasz's rejection of mental illness have both been roundly criticized as nothing more than historical fiction interlaced with philosophical argumentation. Roy Porter, in particular, has criticized both accounts as facile:

> It would be simplistic to cast the rise of institutional psychiatry in crudely functional or conspiratorial terms, as a new witch-hunt or a tool of social control designed to smooth the running of emergent industrial society. The asylum solution should be viewed less in terms of central policy than as the site of myriad negotiations of wants, rights, and responsibilities, between diverse parties...The confinement (and subsequent release) of a

> sufferer was commonly less a matter of official fiat than the product of complex bargaining between families, communities, local officials, magistrates, and the superintendents themselves. The initiative to confine might come from varied sources; asylums were used by families no less than by the state; and the law could serve many interests.[50]

In resonance with Porter's point, I contend that we should maintain a critical perspective on the social constructionists' evidence as being perhaps less literal historical reports but rather more of a set of embellished episodes that are meant as cautionary tales. At least this is how I will interpret much of the anti-psychiatry and social constructionist arguments. In discussions related to the historical-social underpinnings of borderline disorder, this point will become clear and important. The historical renderings, metaphors and tropes used to describe the behavior of the borderline woman should be seen as such, and will serve as a set of anti-paradigms in my development of an ethical pragmatic theory mental illness.

Conclusion

To end this chapter, I wish to preview what a pragmatic theory of mental illness might look like in comparison to the standard theories of health, disease and illness presented above. I wish to highlight four important and interrelated dimensions to the pragmatic theory of mental illness that set it apart from the standard theories. First, although it will be an extension of a hybrid account of disorder that is built upon a naturalistic core, a pragmatic theory of mental illness need not be based on a deeper metaphysical grounding about the "true" nature of health and disease. This is to say, determining a biological dysfunction will not be a necessary condition for the ascription

of mental illness. What shall happen, as I develop this theory, is that the naturalistic core of cases like depression and schizophrenia will provide analogical starting points for marking out instances of social dysfunction. But then the naturalistic core will fade into the background. Social dysfunction will be sufficient (with caveats, of course) to define mental illnesses such as personality disorders. Thus, the pragmatic theory seeks to move beyond the incommensurable metaphysical arguments about health, disease and illness in a move that mirrors Kant's in *Anthropology*.

Second, a pragmatic theory of mental illness will be transparent in the way sociocultural values are integrated and used. Thus, it will be overtly normative. It therefore becomes imperative that a pragmatic theorist of mental illness straightforwardly reveals her practical goals and that the efforts of professional bodies to create disease categories be critically examined according to a systematic analysis. Third, the pragmatic theory of mental illness recognizes the importance and reality of suffering—whether it is of the mentally ill person, their family and friends, or the community. Further, that the suffering caused by mental illness is best treated by medical professionals and within the domain of medicine. Fourth, recognizing its fallibility, the pragmatic theory of mental illness will be subject to constant review and revision, as it should reflect the values of a just and decent democratic society.

In conclusion, the goal of this chapter was to map the conceptual landscape of the concepts of health, disease and illness to contextualize theories of mental illness. As we have seen, we can distinguish broadly between naturalistic theories and normative theories of disease, from which derivative conceptions of mental illness emerge. Hybrid theories and moderate normative theories attempt to integrate particular objective

scientific realities with recognition of the important role played by social values in the creation of diagnostic categories. Social constructionists and anti-psychiatry proponents argue that mental illness is nothing more than the singling out of socially inconvenient or deviant behavior and, as such, mental illnesses are social constructions, which are aimed at curtailing disruptive behavior or, worse, created to justify the incarceration of people who present as threats to political or moral authorities. As we will see in the Chapter 3, recent pragmatic theories of health, disease and illness provide a starting point for extending the discussion beyond irreconcilable debates about the ontology of mental health and illness. We will find, however, that these pragmatic theories provide little in the way of needed ethical resources for their application.

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1. For an excellent account of the diverse set of explanations and theories, including a tabular summary of these concepts, see: Bjørn Hoffman, "Complexity of the Concept of Disease as Shown Through Rival Theoretical Frameworks" *Theoretical Medicine* 22, no. 3 (2001): 211-236. The medical and social models of disability are described by Ron Amundson, "Disability, Ideology, and Quality of Life: a Bias in Biomedical Ethics," in *Quality of Life and Human Difference*, ed. David Wasserman, Robert Wachbroit, and Jerome Bickenbach (New York: Cambridge University Press, 2005), 101-124.

2. Campbell et al. (as cited by Hofmann); Reznek (as cited by Hofmann); Jaspers (as cited by Hofmann)

3. Bjørn Hofmann, 2001 (See n. 1); Marc Ereshefsky, "Defining 'Health' and 'Disease'," *Studies in the History and Philosophy of Biological and Biomedical Sciences* 40 (2009): 221-227.

4. Meta-analyses of theories of health and disease, such as Marc Ereshefsky's, use this tripartite distinction. See: Ereshefsky, 2009 (See n. 3)

5. Virchow stated that "[t]his view is clearly ontological...an *ens morbi* does exist, just as there is an *ens vitae*; in both cases a cell or a cell complex is entitled to be so named." Rudolf Virchow, "Three Selections from Rudolf Virchow," in *Concepts of Health and Disease*, ed. Arthur Caplan, H.Tristram Engelhardt, and James McCartney (Reading, MA: Addison-Wesley, 1981), p. 191. Vichow distinguished the cause (*causa morbi*) from the *ens*. Engelhardt, 1981 claims that the ontological concept refers to both a thing (ens) and a logical type. James A. Marcum, *An Introductory Philosophy of Medicine: Humanizing Modern Medicine,*(New York: Springer, 2008), p. 65.

6. Christopher Boorse, "On the Distinction Between Disease and Illness," *Philosophy and Public Affairs* 5, no. 1 (1975): 55-56.

7. J.G. Scadding, "Diagnosis: the Clinician and the Computer," *Lancet* 2, no. 7521 (1967): 877-882.

8. Christopher Boorse, "A Rebuttal on Health," in *What is Disease?* ed. James M. Humber and Robert F. Almeder (Totowa, N.J.: Humana Press, 1997), 3-134.

9. Ibid., 8.

10. Boorse, 1975, 57.

11. Ibid., 56.

12. Ibid., 61.

13. World Health Organization, *Preamble to Constitution of the World Health Organization*, Geneva: WHO, 1948.

14. Christopher Boorse, "Health as a Theoretical Concept," *Philosophy of Science* 44, no. 4 (1977), 542.

15. See: Samuel A. Cartwright, "Report on the Diseases and Physical Peculiarities of the Negro Race," in *Health, Disease, and Illness: Concepts in Medicine,* ed. Arthur L. Caplan, James J. McCartney, and Dominic A. Sisti (Washington, DC: Georgetown University Press, 2004), 28-38; H. Tristram Engelhardt, "The Disease of Masturbation: Values and the Concept of Disease," in *The Concepts of Health and Disease*, ed. H. Tristram Engelhardt and James J. McCartney (Reading, MA: Addison-Wesley, 1981), 267-280; J. T. Richardson, "The Premenstrual Syndrome: A Brief History," *Social Science and Medicine* 41, no. 6 (1995): 761-767; Frances B. McCrea, "The Politics of Menopause: The 'Discovery' of a Deficiency Disease," *Social Problems* 31, no. 1 (1983): 111-123.

16. Cartwright, 2004, 29.

17. Elaine S. Abelson, "The Invention of Kleptomania," *Signs* 15, No. 1 (1989):123-143.

18. Marilyn Frye, *The Politics of Reality: Essays in Feminist Theory* (Freedom, CA: Crossing Press, 1983); Susan Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992).

19. Ron Amundson, 2005.

20. Engelhardt, 1981.

21. Whales are obviously not fish, though they were long classified as such. Similarly, the naturalist would argue, drapetomania was never a disease though it was classified as one.

22. Boorse. 1997, 77.

23. H. Tristram Engelhardt, *The Foundations of Bioethics* (New York: Oxford University Press, 1996), 218.

24. Peter Sedgwick, *Psychopolitics* (New York: HarperCollins Publishers, 1982), 30.

25. James A. Marcum. 2008, 72.

26. Ibid., 71.

27. Engelhardt, 1996, 196.

28. Joseph Margolis, "The Concept of Disease" in *The Concepts of Health and Disease,* ed. Arthur Caplan, H. Tristram Engelhardt, James McCartney (Reading, MA: Addison-Wesley, 1981), 561-577.

29. K. Danner Clouser, Charles M. Culver, Bernard Gert, "Malady: New Treatment of Disease," *Hastings Center Report* 11, no. 3(1981): 29-37.

30. Ibid., 36.

31. Ibid.

32. Jerome C. Wakefield, "The Concept of Mental Disorder: On The Boundary Between Biological Facts and Social Values," *American Psychologist* 47, no. 3 (1992): 373–388.

33. Ibid., 374.

34. Jerome C. Wakefield, "Aristotle as Sociobiologist: The Function of a Human Being Argument, Black Box Essentialism, and the Concept of Mental Disorder," *Philosophy, Psychiatry, and Psychology* 7, no. 1 (2000): 20.

35. Wakefield, 1992, 383.

36. Ibid., 382.

37. Ibid., 383.

38. Ibid., 384.

39. Ereshefsky, 2009, 226.

40. Ibid., 226.

41. Ibid., 227.

42. Mary Tiles, "The Normal and Pathological: The Concept of a Scientific Medicine," *The British Journal for the Philosophy of Science* 44, no. 4 (1993): 736-737.

43. Richard Horton, "Georges Canguilhem: Philosopher of Disease," *Journal of the Royal Society of Medicine* 88, no. 6 (1995): 316–319.

44. Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Random House, 1965), 83.

45. Michel Foucault, *Introduction to Kant's Anthropology*, trans. and ed. Roberto Nigro, trans. Kate Briggs (Los Angeles, CA: Semiotext(e), 2008.), 54.

46. See Immanuel Kant, *Critique of Pure Reason*, A341/B399.

47. Thomas Szasz has argued he has been mischaracterized as proponent of "anti-psychiatry" most recently in his book *Antipsychiatry: Quackery Squared* (Syracuse, NY: Syracuse University Press, 2009). I will, nonetheless, use this term to describe Szasz's brand of strong constructionism of mental illness.

48. Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, New York: Paul B. Hoeber, 1961.

49. This is why there is confusion about how to classify Szasz. "Many of those who point to examples of the abuse of disease concepts are pointing out the way these are contaminated by value assumptions. But it may often be unclear whether they are objecting to the specific values at work, or to the idea that values should play any role in the ascription of disease." (Tom Tomlinson, pers. comm., 2010)

50. Roy Porter, *Madness: A Brief History*, (New York: Oxford University Press, 2002), 98-99.

CHAPTER 2

THE CONCEPTS OF BIOLOGICAL & SOCIAL (DYS)FUNCTION

Introduction

In this chapter, I will begin by drawing a key distinction that, I will then argue, necessitates the move from a naturalistic theory of mental illness to a pragmatic theory. The key distinction to be drawn is between two kinds of function concepts: biological and social. It is first necessary to distinguish between function concepts to then justify the ontological commitment I will be making in drawing a second, but related, distinction between two broad categories of mental illness: core cases and boundary cases of mental illness. I will exemplify this second distinction using the case of schizophrenia to illustrate core cases and the borderline personality disorder to describe boundary cases.

It is crucial to talk about function first, because I will argue that, at least with respect to core cases of mental illness, Boorse's biostatistical theory of disease (BST) and Wakefield's harmful dysfunction (HD) theory are theoretically satisfactory.[1] In particular, Boorse's concept of biological function, which grounds his BST has been exceptionally resilient to critique. Thus, Boorse's and Wakefield's theories provide a sufficient explanation to justify medical intervention in core cases of mental illness. However, in order to eventually show why a pragmatic theory is needed for boundary cases of mental illness, I will explain why I believe these naturalist-hybrid theoretical models ultimately fail in pinpointing the essence of social dysfunction, which by definition is a marker of a personality disorder. This is to say, naturalist or hybrid theories fail to provide sufficient justification for treating personality disorders as medical conditions. I will be arguing that personality disorders should count as medical conditions

and that for these boundary cases of mental illness a pragmatic theory offers the kind of explanatory power needed to categorize constellations of socially dysfunctional behavior as mental illnesses. This is all meant to lay the foundation for my work in chapter 3, where I introduce other pragmatic theories of mental illness and begin to detail the pragmatic theory I offer, which turns on the concept of social dysfunction.

Thus, the goal of this chapter is twofold: (1) to explain the key distinction between core and boundary cases of mental illness by defining them in terms of biological and social function, respectively, and (2) to being illustrate these function concepts with regard to core and boundary cases. My aim is to set the stage for my pragmatic theory of mental illness by showing why personality disorders ought to be included as mental illnesses on the grounds that they represent a particular kind of social dysfunction and that naturalist models are too limited for this purpose.

Pluralism & Function Concepts

As Kitcher has argued, fundamental philosophical concepts such as 'species' or 'function' should be understood in terms of what he calls pluralistic realism.[2] This simply means that theoretical understandings and applications of the concept of function will be (and should be) different for each particular subdiscipline of biology and community of biologists. Likewise, dysfunction will mean something very different to the ethologist, cladist, or ecologist as it might for the virologist or cell biologist. This is not to say 'function' is an altogether relative concept. A virtue of a good theory of function is that it should remain constant and should provide the necessary scope to handle a variety of cases—from the function of artificial devices to organic processes. But instances of what

is considered to be a *relevant* function or dysfunction might vary across the reference class a biologist is examining. It is in the spirit of Kitcher's pluralistic realism that I focus on those functional concepts that seem to be most germane to naturalistic nosology. And so, I wish to restrict my discussion of function to those theories that underpin Boorse's naturalism and will leave aside complicated questions related to functional statements about human artifacts or more fine-grained evolutionary arguments about improvised functions known as exaptations. Moreover, my commitment to pluralistic realism on function will be important as we begin to examine the unique dimensions of dysfunction represented by the personality disorders.

As I mentioned above, I believe Boorse's BST is adequate in dealing with somatic disease and core cases of mental illness. To defend this claim, I will first articulate Boorse's concept of function as it pertains to both somatic and psychological disease. Of course, because species typical function is the conceptual foundation of his concept of disease, an assessment of the concept of function is essential in determining what should be included in the naturalist's ontology of disease, disorder, and illness. If Boorse's concept of function is fundamentally flawed, his BST will be shown to be hopelessly misguided.

As I mentioned in Chapter 1, Boorse's concept of species typical function is not without its problems; so I will address the more significant objections to this concept and then offer replies on Boorse's behalf. Again, my immediate goal here is to persuade you, the reader, that a level of theoretical adequacy is met by Boorse's theory for core cases of mental illness and prepare to show that the theoretical limitations of the concept of function are too narrow to provide a rich account of the ontological status of personality

disorders. Let us first begin with a survey of the concept of function as it is typically applied to cases somatic disease *qua* organ or cellular dysfunction and then we will look at how it applies to core cases of mental pathology.

Biological Function

Arguments about the nature of 'function' locate their roots in ancient philosophy. Ever since Aristotle's zoological studies, the concept of biological function has been bound up with teleology in one sense or another. That is, the function of a cell or organ, for example, has been typically defined in terms of an activity that contributes toward the goal of the larger system within which the cell or organ is situated. As is well known, according to Aristotle the *telos*—or final cause—of the individual animal was specific to that animal and implied no external directedness or purposefulness. Rather, the final cause of an animal is simply to become an individual of the particular species. Indeed, in the lexicon of Aristotelian causes, the *telos* of a natural thing is also part of its *formal* cause and not simply its *final* cause. In other words, the form of the cell or organ is a reflection of its final cause and vice versa. For example, the form of the eye is as it is for the function of sight. Likewise, the function of the heart is to pump blood, and not to, for example, make its characteristic thumping sound. This basic Aristotelian account of biological function is likewise reflected in the first of Tinbergen's four why-questions pertaining to the ultimate or evolutionary explanations of adaptations, i.e. they contribute to the ultimate success of the organism though survival and reproduction.

In 1973, Larry Wright developed a more refined theory of biological function, which is well known to philosophers of biology.[3] In his seminal paper "Functions," Wright argues that functions can be distinguished from other often-confused concepts such as goals, indefinite versus definite functions (i.e. *a* function vs. *the* function), accidental activity, and conscious functions (i.e. those imputed to an intelligent designer). All of these other confounders, Wright argues, complicate what a function really is because they hearken back to pre-Darwinian thinking. Wright distills his so-called etiological definition of function thusly,

> The function of X is Z means:
>
> (a) X is there because it does Z,
>
> (b) Z is a consequence (or result) of X's being there.[4]

He goes on to illustrate how his account of function offers an explanation about not just what a function is based on its etiology, but also what it is about functions that is teleological. He states:

> The first part, (a), displays the etiological form of functional ascription-explanations, and the second part, (b), describes the convolution which distinguishes functional etiologies from the rest. It provides an etiological rationale for the functional "in order to," just as recent discussions have for other teleological concepts.[5]

Wright's etiological account of function stands in contrast to Cummins's theory of function, which locates the essence of function in the identification of causal contributions to complex physiological processes.[6] Cummins argued that function should be assessed without an appeal to the origin of the particular part, but rather through an

analysis of that part's role or capacity within a particular system. Cummins summarizes this position in the conclusion to his 1975 article "Functional Analysis":

> To ascribe a function to something is to ascribe a capacity to it, which is singled out by its role in an analysis of some capacity of a containing system. When a capacity of a containing system is appropriately explained by analyzing it into a number of other capacities whose programmed exercise yields a manifestation of the analyzed capacity, the analyzed capacities emerge as functions.[7]

Thus, we can understand the function of the heart to be to pump blood not because of its presence and etiology, but its contribution to the larger circulatory system.

But both Wright's and Cummins's accounts of function suffer from complementary flaws. First, Wright's theory seems to be too restricted in that it captures only a very specific kind of functional adaptation produced by natural selection. A classic counterexample is that of feathers in birds. It is thought that feathers were originally selected for their utility in maintaining homoeothermic balance, but then were later co-opted for use in flight. Thus, as Kitcher explains, etiological explanations of function must be disambiguated to account for the function of a feature in the here-and-now versus what was ostensibly its original functional contribution.[8]

In Cummins's theory, we see a reciprocal kind of problem. His theory seems to be too loose because it encompasses too many instances of stochastic events as "causes" that might be interpreted in some way as being functional. The counterexample to Cummins's model is portrayed by the example in which there is an arrangement of rocks in a stream, which causes a particular flow of water that results in a widening of the

stream miles away. On Cummins's account, because of their contribution to the system of the stream, the widening of the stream should be considered the function of those rocks. This of course seems preposterous, since there is no basis for determining that those rocks are there for the purpose of stream-widening. Therefore, the recognition of some token's contribution or capacity to contribute to some feature of a larger system is simply not sufficient for labeling it a function.[9]

Boorse offers his own theory of function to ground his BST, which is largely based on a previous theory of function of by Sommerhoff as well his objections to both Wright's and Cummins's models. Quite simply, Boorse returns to an Aristotelian notion of biological function, stating that function,

> ...in the biologist's sense is nothing but a standard causal contribution to a goal actually pursued by the organism. Organisms are vast assemblages of systems and subsystems which, in most members of a species, work together harmoniously in such a way as to achieve a hierarchy of goals. Cells are goal-directed toward metabolism, elimination, and mitosis; the heart is goal-directed toward supplying the rest of the body with blood; and the whole organism is goal-directed both to particular activities like eating and moving around and to higher-level goals such as survival and reproduction. The specifically physiological functions of any component are, I think, its species-typical contributions to the apical goals of survival and reproduction.[10]

And in another paper, Boorse clarifies this definition by reminding opponents that his theory is not altogether novel, but is rather the same classical understanding of

nonpurposeful teleology that had been recently refined by contemporary philosophers of biology and cybernetics: [11]

> In my view the basic notion of a function is of a contribution to a goal. Organisms are goal-directed in a sense that Sommerhoff, Braithwaite, and Nagel have tried to characterize: that is, they are disposed to adjust their behavior to environmental change in ways appropriate to a constant result, the goal. In fact, the structure of organisms shows a means-end hierarchy with goal-directedness at every level.[12]

Boorse stipulates that, although there will be various goals depending on level of selection (gene, cell, organ, etc.), the basic notion of function will work in each and every one of these contexts. No matter the specialization of the biologist, each should be able to see function in this fundamentally value-free way. For discussions of health, disease, and illness, Boorse argues that it is the physiological notion of function that should remain central to our analysis:

> Most behavior of organisms contributes simultaneously to individual survival, individual reproductive competence, survival of the species, survival of the genes, ecological equilibrium, and so forth. As a result, it appears that different subfields of biology (e.g., genetics and ecology) may use different goals as the focus of their function statements. But it is only the subfield of physiology whose functions seem relevant to health...This assumption has definite consequences for our health concept and should therefore be kept in mind. Whatever goals are chosen, function statements

will be value-free, since what makes a causal contribution to a biological goal is certainly an empirical matter.[13]

Boorse stipulates his definition of "normal function of a part or process within members of the reference class is statistically typical contribution by it to their individual survival and reproduction."[14] Thus, the reference class is defined as an ideal individual member of the species. This 'ideal' is not a normative or ethical ideal but rather an ideal in the Platonic sense. It is a reflection of the ideal form of the species that can be envisioned through statistical analysis of a large sampling of particular traits of individuals within a species. This is the form that we so often find in the images or diagrams of anatomy or physiology texts.

Several objections have been raised against Boorse's concept of function. One well-developed and persistent objection comes by way of K.W.M. Fulford who claims that Boorse's concept of function is covertly normative. Fulford develops this objection first by highlighting Boorse's use of what he calls 'evaluative' terminology in discussing instances of dysfunction and disease. Fulford essentially argues that the term 'dysfunction' cannot be employed descriptively— particularly in the context of medicine— without it betraying a value judgment about that which is deemed 'dysfunctional.[15] Invoking Austin, Fulford claims that Boorse's word choice and his examples expose this normativity. He states,

> The key methodological insight of linguistic-analytic philosophy, as described most explicitly by the Oxford philosopher, J.L. Austin, is that the words we use may act as a kind of analytical probe to, or microscope on, meanings...Hence our use of such concepts, i.e. the words we use for

> real, may be a surer guide to their meanings than attempts to define them. Hence Boorse's use of "disease" with evaluative connotations may signal that, his value-free definition of disease notwithstanding, there is an essential evaluative element in the meaning of the term.[16]

Without delving too deeply into the particulars of the philosophy of language here, Fulford seems to be on to something about the difficulty of abstracting a concept like biological function away from its medical context (at least in nosological theories) without keeping the residue of certain evaluative elements created by the original context. Because of linguistic difficulty, Fulford thinks Boorse (as with other naturalists) is guilty of making a sort of equivocation, "through inconsistency, through his repeated slips from value-free *definition* to value-laden *use* of the concept."[17] One way to disentangle, or at least make transparent, this confusion is to distinguish between the "doing" aspects of function. In these cases dysfunctional "doing" applies to parts of organisms, while the problems of "ordinary doing" reflect illness. It is in the conflation of what's doing what that causes confusion.[18]

Fulford's second objection is related to his first and aims at the heart of Boorse's concept of function by taking issue with the broader attempt by philosophers of biology to disentangle function and teleology in a meaningful way. Fulford claims that any account of function that takes teleology seriously must in some way be evaluative. He argues that,

> ...[this] point is an extension of that made above against naturalism on disease." The concept of a "goal", being a teleological concept, *does* allow us to speak of good and bad functioning by reference to whether or not the

> goal in question is attained. But this is because goal itself, to the extent that it is a teleological concept, carries an evaluative element of meaning. A goal is not, merely, something which is hit or missed, as, say, a comet merely hits or misses a planet: a goal is aimed at or targeted; it may...be desired, needed, wished for, intended, etc; a goal is something which (in itself) it is good to hit and bad to miss.[19]

Again, this objection makes sense when we consider the linguistic usage of function claims particularly within a medical context. Fulford's objection appeals to the intuition that goals must be considered valuable in some sense; without such value a goal is no longer a goal. Such a 'valueless' goal would be nothing more than a random destination. Indeed, most normativist critics of Boorse articulate this objection in some way or another.

But for both of these objections, Boorse supplies reasonable and, in my opinion, compelling rejoinders. First, Boorse answers Fulford's linguistic attack by showing that his use of words to describe states are not necessarily evaluative, and Fulford seems to be excessively reading norms into Boorse's statements. Fulford, as Boorse notes, offers an oddly expansive list of ostensibly evaluative terms. To wit, Fulford even claims Boorse's use of the word 'kidney' is value-laden. Aside from pointing out the absurdity of this claim, Boorse reminds us that his function concept relies on the "natural polarity" of physiological processes, which, again, has been well-developed in the philosophy of biology literature and based on classical theories. Reminding us that his concept of function is based on Sommerhoff's more basic concept of value free functional goal directedness (which drives an even deeper distinction between living and non-living

things) and Nagel's systems approach to defining function, Boorse illuminates his rejoinder:

> The function of a physiological process is its contribution to physiological goals. By 'deficiency' of function, then I mean simply less function, less contribution to the goals, than average. This is an arithmetic, not an evaluative, concept. An easy example is homeostatic functions like regulation of body temperature or of blood pressure, gases, or electrolytes. Insofar as what regulates these variables is directed to the physiologic goal of constancy, deficient function is simply much greater variation, much wider swings, than average, or failure to return from one at all.

Approaching from a slightly different flank, Engelhardt also attacks Boorse's concept of function. Among other things, Engelhardt claims that Boorse's 'function' is based on the survival of the species. This he claims is the wrong level of concern for medical purposes because the goal of medicine is not the species but the well-being of the individual patient. In other words, Engelhardt claims that Boorse gets the level of selection for medical practitioners, as it is defined in terms of species typical function, wrong. Moreover, Engelhardt claims that Boorse's theory is normative because the choice to prioritize species-typical over individual function is a value-based decision. Boorse, who replies that Engelhardt is misinterpreting his theory, summarily discharges this objection. Reiterating Somerhoff, Boorse claims that nothing about species selection is normative—it simply is the case that a disease *is* best viewed by noting average function and deviations therein. Species is simply the classification or category needed to

survey the landscape of averageness of individuals within that reference class. I will say a bit more on this below.

One of the potentially stronger objections to Boorse's theory of dysfunction-as-disease is the popular claim the Boorse conflates 'difference' with 'dysfunction'. This objection will be detailed more closely in the next section on mental illnesses because I think it holds some merit in that context. However, in the context of somatic dysfunction, I think Boorse would argue that his opponents should not misconstrue his definition of dysfunction as being synonymous with a folk definition of 'difference.' In fact, his concept of function allows for an infinite array of differences. But it is those very specific differences that undermine the ability of the organ or system or individual to achieve their larger goals of survival and reproduction that are salient to Boorse. This is to say, only consequential differences matter for Boorse. One reply would be that Boorse's logic belies a genetic fallacy in that we are judging function arbitrarily or exclusively on the goals of survival and reproduction and there might be other important goals against which to judged function. This is a fair point—if we are willing to concede naturalistic ground to normativists. The claim that survival and reproduction are *the* goals that matter the most is a stipulation; however it is not arbitrary. It is one that serves as a starting principle of evolutionary biology and thus naturalistic nosologies.

An allied and persistent objection posits that Boorse's theory ignores evolutionary biology because it idealizes uniformity across a species. According to this argument, Boorse fails to recognize that variation and diversity are natural, and, moreover, drive evolutionary change. Thus, by basing dysfunction on species typicality Boorse is misguided because he idealizes species uniformity. This interpretation of Boorse

however is mistaken. Boorse clearly argued that his concept of function is not meant to account for the epochs of evolutionary diversity and change. Rather, his use of the concept of function is meant to explain disease at the immediate physiological level, where species diversity is in fact quite narrow. Indeed, the establishment of a trait within a species is marked by such uniformity. Otherwise, it would not really be a trait. As Boorse states, "On all but evolutionary time scales, biological designs have a massive constancy vigorously maintained by normalizing selection."[20]

Nonetheless, despite Boorse's clear replies, this set of objections has persisted in the literature since the 1970s. For example, Bolton has recently reiterated the claim about difference-dysfunction conflation as one of the more devastating objections to Boorse's concept of function. This objection, Bolton claims, is even more potent today because of it has been amplified by those in the disabled community:

> Whatever may have been the attraction of Boorse's analysis several decades ago, as a response to the 1960s controversies, it is particularly problematic now in its proposal that mere statistical difference from some population norm constitutes disease or some mental equivalent. It invites the protest from individuals with such conditions— now that they have a voice— that difference is being pathologized and hence disqualified. [21]

Bolton's confidence in this objection might be well-placed in a certain political sense, but I think it misses the mark in refuting Boorse's actual theory. Simply because Boorse's argument is now considered to be politically distasteful to some individuals does not, in fact, make it theoretically unsound. Therefore, Bolton's endorsement of this objection is nothing more than an instance of the bandwagon fallacy.

My point in presenting these thumbnails of objections to Boorse's concept of function is simply to provide enough background to claim that, while Boorse has been subjected to withering criticism over the past four decades, his concept of biological function stands up remarkably well to those attacks. Boorse's core concept of species typical function—at least when referring to physiological functions—seems to be about as objective as it gets when talking about any scientific concept. As Boorse himself admits, of course, scientific concepts will be impregnated with a certain amount of 'value' brought to their investigation by the human investigator. Does this mean that laws, theories or concepts like gravity, quantum mechanics or ideal gasses should be under suspicion as normatively biased social constructions? And is the positivistic standard impossibly high for concepts related to human health, disease, and illness? Perhaps the level of "value-ladenness" found in the theories of particle physics or chemistry instills less worry because theoretical constructions in the physical sciences not only seem more "objective" in the positivistic sense, but also because these theories do not have a direct impact on our daily life and welfare the way medical concepts might.

Ironically, however, while I think Boorse's concept of function works well for explaining the necessary and sufficient conditions of somatic diseases, I will argue it is deficient for explaining those of a mental illness. I say this is ironic because mental illness was actually a primary aim of Boorse's theory when he first developed it. So let me now explain why I find his concepts of function and dysfunction to be too limited when used to mark out what should count as a mental illness.

Dysfunction & Mental Illness

In the first of Boorse's original quartet of papers where he describes his theory of disease and illness, he assumes that there are "natural mental functions and also that recognized types of psychopathology are unnatural interferences with these functions."[22] This assumption is then explained in his article, "What a Theory of Mental Health Should Be." Here Boorse explains that the mental functions can and should be defined in the same way as biological functions. Mental processes can be understood as both causally necessary to an individual's actions, and contribute in some species typical way to that individual's overall fitness. Thus, there can be disturbances in these processes that are dysfunctional and deviate from species typicality, which therefore count as mental diseases. However, we should be clear here: Boorse is not a mere materialist on mental disease and illness. He does not think that mental processes need always be tied to some physiological correlate (though they might be). What he argues is that mental states need not have identifiable correlative physical states. This would be analogous to when a computer's software is malfunctions; it would be a mistake to look only for a broken piece of hardware to repair it. Likewise, although there might be a physical injury that has caused a dysfunctional mental state, because a brain lesion is not apparent does not rule out a mental malfunction. Mental states can themselves be the causes of mental dysfunction by virtue of the fact that, for Boorse, normal and functional mental states exist.

Boorse defines the normal mental state in terms of psychoanalytic theory reinforced by contemporary physiological research. He argues that while it might be impossible to identify the location of a mental state within the human mind, there is a

particular species-typical map of the mind that, although not yet anatomically defined, can be assumed to be present as the origin and cause of mental states. Indeed, Boorse recounts Freud who anticipated a reduction of psychoanalytic theory to its physiological basis when in 1915 he said, "Our psychical topography has *for the present* nothing to do with anatomy; it has reference not to anatomical localities, but to regions in the mental apparatus, wherever they may be situated in the body."[23] Moreover, Boorse suggests that Freudian psychoanalytic theory is analogous to a physiological model because the substructures of the mind—the id, ego, and superego—are the basic systems of mental activity. Speaking specifically of the those substructures, Boorse states that

> ...it is not entirely clear that the mental functions psychoanalysts describe are functions in the biological sense. One sometimes has the impression in psychoanalytic writing that the function of a mental process is the gratification it can secure for the id. From the biological standpoint, the function of a mental process is its contribution, not to our pleasure, but to our behavior; pleasure itself has a function in producing behavior. *But it would not be difficult to construe psycholanalytic theory as a set of theses about biological functions of the mind.* On this view the id might emerge as a reservoir of motivation, the ego as an instrument of rational integration and cognitive competence, and the superego as a device for socialization.[24] (italics mine)

Of course, opponents who think this analogy is overly simplistic have attacked. For example, Lavin has claimed that the psychoanalytic concept of function is different than that of the physiologist, particularly because the substructures of the psyche "never fail"

in performing their requisite roles like physiological parts might. Boorse discharges this claim by simply stating that they must be vulnerable to dysfunction since that is what psychoanalysis treats.[25] I think if we take this analogy more literally, a stronger objection would be that it assumes the etiology of mental dysfunction to be ultimately developmental. On the psychoanalytic account, the cause of most mental illnesses can be located in a dysfunctional relationship with one's parents, which somehow triggered a maladaptive physiological response. This entails mental illnesses are not in fact biologically based but, rather, they emerge from dysfunctional parent-child relationships. In other words, by choosing psychoanalytic theory as his model of mental illness, Boorse seems to undercut his own goal of locating mental illness within the sphere of biological function.

Additionally, for Boorse to endorse psychoanalytic explanations as the most feasible route toward a value-free concept of mental illness has always seemed strange to me. Notwithstanding the fact that full-blown Freudian psychoanalysis has fallen into disrepute in mainstream psychology, it seems undeniable that psychoanalytic theory is deeply value-laden, because, for example, it idealizes particular parental and gender roles and social dynamics as being healthy. The larger objection that psychoanalysis simply reflects or endorses particular moral values is crystallized by Joseph Margolis who posits that the therapeutic role of the psychoanalyst is to routinely prescribe moral and ethical kinds of "treatment" for their patients. Thus, work of the psychoanalyst is primarily morally normative because their prescriptions are ultimately ethical decisions about what constitutes the good (or less bad) life for that patient. [26] Without exploring the more specific arguments about the scientific status of psychoanalysis, suffice it to say,

psychoanalysis is not considered to be a paragon of objective and positivist science. While it might have scientific merit, I think it is reasonable to assert the methods of traditional Freudian psychoanalysis do not pass the scientific test for falsifiability like particle physics or biochemistry.[27]

To summarize, for Boorse, as with any other kind of dysfunction, mental dysfunctions are diseases. He is critical of theorists and clinicians who think that mental health is something "more grandiose" than this very basic definition of psychic pathology. Because the substrata of the mind function in ways that should promote individual fitness, those functions can be assessed according to the same criteria as physiological functions. With this basic account of mental function explicated, Boorse then goes on to explain when and how particular mental diseases should be considered mental illnesses. He singles out the paradigm case of schizophrenia and explains why personality disorders might be left out of his nosology:

> Finally, the hope for contrasting responsible people with their mental diseases grows vanishingly dim in the case of a character disorder, where the unhealthy condition seems to be integrated into the conscious personality...If the term "mental illness" is to be applied at all, it should probably be restricted to psychoses and disabling neuroses...It seems doubtful that on any construal mental illness will ever be, in the mental-health movement's famous phrase, "just like any other illness."[28]

As we now see, the line for mental illness circumscribes only those instances of mental activity or behavior that can be defined in terms of psychological dysfunction, which, in turn, must be determinable by some objective, possibly physiological, measure. By now,

with all or our previous discussion about the aspirations of Boorse and the naturalists, this conclusion should not come as a surprise.

Let us now briefly turn to Jerome Wakefield's theory of function. In much the same way as Boorse, Wakefield claims that biological functions are completely value neutral, while the degree to which these dysfunctions are harmful is a normative judgment. Although Wakefield's harmful dysfunction model of mental illness largely parallels Boorse's BST, a few important concepts should be reemphasized here. Indeed, the limitations of Boorse's function concept are even more clearly seen in Wakefield's harmful dysfunction theory particularly in the way Wakefield hopes to eventually explain personality disorders. Resonating with Boorse, Wakefield describes function in a very specific medical sense. He states, "Function and dysfunction in the medical sense refer, in the first instance, not to the quality of a person's performance in a given environment but to whether mechanisms within the person are performing or failing to perform functions they were designed to perform."[29] A dysfunction for Wakefield is defined as, "a scientific term referring to the failure of a mental mechanism to perform a natural function for which it was designed by evolution." Wakefield thinks that cognitive mechanisms can be assessed in terms of their evolutionary use and, in agreement with Boorse, can be understood as analogous to physiological mechanisms:

> Mental mechanisms like those involved in perception, motivation, emotion, linguistic ability, and cognition play distinctive but coordinated roles in overall mental functioning, much as different organs play distinctive but coordinated roles in physical functioning. Thus, a biological account based on evolutionary theory has seemed to many to be

potentially capable of handling the concepts of both mental and physical disorder in a scientific and value-free manner. [30]

For Wakefield, though they might be difficult to pinpoint, mental function and dysfunction can be determined as purely value-free scientific assessments. It is true that figuring out the 'natural' or functional mechanism of a mental process can be incredibly difficult. Wakefield concedes this is far more difficult to determine than a biological mechanism. He claims however that our ignorance about what constitutes functional mental mechanisms should not deter us from hypothesizing what we think mental mechanisms are functionally designed to do. He states:

> This ignorance is part of the reason for the high degree of confusion and controversy concerning which conditions are really mental disorders. Paradoxically, this ignorance about the detailed nature and causal histories of mental mechanisms also makes it all the more necessary to rely on functional explanations based on inferences about what mental mechanisms are probably designed to do. In this respect, we are now at a stage of understanding that is comparable in some ways to the position of ancient physicians who had to rely on similar inferences in judging physical disorder... As we learn more about the naturally selected functions of mental mechanisms, our judgments about dysfunction will become correspondingly more confident.[31]

Wakefield's conjecture that we will more reliably determine the biological (or evolutionary) bases for mental illnesses—including personality disorders—is

overly optimistic because, as I argue in the next section, it is impossible to determine the function of a personality in a value-free way.

Likewise, it turns out Boorse's and Wakefield's theory of dysfunction both fall short in marking out all mental illnesses *not* because they are covertly normative or internally flawed, but because they may actually be *too successful* in being value-free. The critics of Boorse fail to see this possibility as a potential problem with his theory because they are too preoccupied defending the (ideological) claim that all nosological theories must, in one way or another, be normative constructions. They fail to consider the possibility that, no, not all theories need be normatively infected and that, alternatively, objective frameworks like Boorse's may actually be flawed for other reasons. It thus is plausible that Boorse's theory is simply "too objective" to adequately explain what should count as a mental illness. This is basically my position, and I will now begin to illustrate my reasoning more carefully below. My pragmatic theory, as I hope to show, emerges from the ramifications of this position *vis-à-vis* personality disorders.

Biological versus Social Dysfunction: Schizophrenia & the Disordered Personality

To more fully distinguish between function concepts and core and boundary cases of mental illness, let us now contrast, briefly, two kinds of mental illness: schizophrenia and personality disorders. Schizophrenia should serve to illustrate how biological dysfunction might be determinative of mental dysfunction. Thus, I will assume schizophrenia exists and will set aside Szasz's radical claim that schizophrenia is nothing more than a social contrivance invented by medical authorities to underpin their ulterior

political motivations.[32] For purposes of this discussion, we will keep the descriptions of each disorder rather general. While it is true that schizophrenia is no longer considered a unified mental illness but a continuum of schizotypical subcategories, for our purposes, we'll consider it to be a broad instance of mental illness. Likewise, personality disorders are a diverse set of mental disorders. In chapters 6 and 7, I will more fully describe the signs and symptoms of the borderline personality disorder as a detailed case study used to illustrate my pragmatic theory of mental illness. For now, let us think about how the concept of function is used to describe schizophrenia and personality disorders in general terms.

Schizophrenia serves as a paradigm case of mental illness across most theories of mental health and illness. The symptoms of schizophrenia include delusions, hallucinations, disorganized speech and behavior; subtypes might include paranoia, echolalia, catalepsy, etc. According to the ICM-10, Schizophrenia, schizotypal and delusional disorders are described across categories F-20 to F-29. Schizophrenic disorders, at the most general level:

> ...are characterized in general by fundamental and characteristic distortions of thinking and perception, and affects that are inappropriate or blunted. Clear consciousness and intellectual capacity are usually maintained although certain cognitive deficits may evolve in the course of time. The most important psychopathological phenomena include thought echo; thought insertion or withdrawal; thought broadcasting; delusional perception and delusions of control; influence or passivity; hallucinatory

> voices commenting or discussing the patient in the third person; thought disorders and negative symptoms.[33]

Similarly, in the DSM-IV-TR the characteristic symptoms of schizophrenia are defined as two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

1. delusions
2. hallucinations
3. disorganized speech (e.g., frequent derailment or incoherence)
4. grossly disorganized or catatonic behavior
5. negative symptoms, i.e., affective flattening, alogia, or avolition

The range of schizophrenia disorders includes a number of more specific subtypes, which are defined based on the variation and specific manifestations of the above characteristics.[34]

For a naturalist, the first question about schizophrenia would be, "Are the characteristic schizotypical behaviors instances of normal species functioning?" Boorse answers this question by arguing first that in severe cases of schizophrenia we can clearly an instance of biological dysfunction:

> Some mental patients, e.g. catatonic schizophrenics, are clearly incompetent with respect to these biological goals and would remain so under almost any circumstances. Whatever the detailed functional 'organization of the human mind and body may be, then, these people ...depart from it and so are authentically unhealthy... [35]

Why might we consider the catatonic or paranoid schizophrenic patient to be dysfunctional and unhealthy? Boorse replies that psychoses are instances of internal conflict between impulses or desires and reality, which, without a functional apparatus

for negotiating this conflict, degrade into disorder. Precisely because the particular mental substructures and cognitions that allow the individual to live according to their desires within the constraints of the real world are degraded in the psychotic patient, they will fail to thrive.

> By this standard schizophrenia and all other psychoses with thought disorders look objectively unhealthy. Moreover, it one accepts the traditional analytic description of the neurotic process, very limited functional assumptions will suffice to construe serious neurosis as a disease. Since opposite desires are common in human beings, there must be some normal mechanism for resolving them without permanent and paralyzing conflict. If some of the neurotic's strongest desires remain locked in combat without freely releasing their motivational force in behavior, it is not an implausible hypothesis that the conflict-resolution mechanism is functioning incorrectly.[36]

Boorse claims that behaviors characteristic of psychotics suffice to show that such behaviors are dysfunctional and are thus unhealthy. Further, they are illnesses by virtue of the norms related to their desirability or social value, which for schizophrenia is clearly undesirable in our society. Boorse states that he is confident that schizophrenia is a dysfunction, and thinks, "Any stronger vindication of current clinical categories would require a detailed and well-confirmed theory of the functions of a normal human mind."[37] Perhaps, by this, he means in part, some well-established empirical data about species typical functioning of the brain. And in fact, as the growing body of empirical research into schizophrenia illustrates, there are statistically significant differences in the anatomy

and physiology of the brains of schizophrenic individuals. It is, in fact, these data about statistically normal brain form and function that bolster the naturalists' theory of mental illness in the case of schizophrenia.

However, I believe personality disorders to be fundamentally different, at least in terms of how they are distinguished from normal personalities. Personality disorders are defined in the DSM-IV-TR as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment." Thus, they are defined in terms of their cultural context and as such, are not dependent on any concept of biological function. In contrast to schizophrenia, lapses in socially determined standards of behavior are sufficient conditions for ascribing the label of personality disorder. This is to say, they rely on a set of cultural expectations about what is socially desirable and acceptable, which, in turn, define personalities that are functional and dysfunctional. We see the appeal to cultural norms as explicitly in the ICD-10 definition for the range of personality disorders (Block F-60 to F-69), "specific personality disorders (F60.-), mixed and other personality disorders (F61.-), and enduring personality changes (F62.-) are deeply ingrained and enduring behavior patterns, manifesting as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others."[38]

As I continue to develop the pragmatic theory, we will see that key markers of personality disorders that make them candidates for mental disorders will be common

features such as the constellations of behavior (to be defined in terms of habits) that are judged to be dysfunctional as well as the form of suffering they cause both to the patient and others. For now, it is important to recall where we have been conceptually: from naturalist arguments we see that biological function claims can be used to make analogical arguments about social function and dysfunction. From there we can see that particular kinds of social dysfunctions may be grounded in biological dysfunction. Such is the case with core cases of mental illnesses like depression and schizophrenia. However, other potential mental disorders lack this biological grounding at present, and remain defined in terms of social dysfunction. In the chapters to come, I will develop my argument that, in short, says that considering particular culturally defined dysfunctions *as if* they are cases of naturalistically defined dysfunctions is a reasonable and defensible pragmatic solution.

Conclusion

This chapter presented a broad overview of the concept of function as it relates both to the biological sciences and medicine. As we saw, naturalists like Boorse rely on a physiological-evolutionary concept of normal function to determine the healthy from the diseased. This concept of biological function is used to discern what should count as a somatic and mental disease. Although his thesis is now sometimes dismissed out of hand, as I have argued, Boorse's naturalistic nosology is remarkably coherent and continues to stand up well to decades of philosophical criticism and, at times, rhetorical sniping. [39] However, it is a victim of its own success in that it is too limited in the way it handles instances of psychological dysfunction- particularly in cases recognizable only by appeals to social dysfunction. Indeed, it has been argued elsewhere that antisocial personality

disorder conflates two "universes of discourse: the universes of personal and social deviance."[40] It will be my task to more clearly parse these universes and show why considerations of social deviance might be ethically used to justify the continued medicalization of personality disorders.

I have shown that social dysfunction is an equally important concept to include in any nosology of mental health. We see instances of how social dysfunction currently characterizes the broad category of personality disorders. Now I must justify why this should be the case and how pragmatic theories will prove helpful in providing a more philosophically robust concept of mental illness. Therefore, my next task is to highlight helpful theoretical starting points found in other pragmatic models of mental illness and describe my own proposal, which I will do in the next chapter.

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1. Since Wakefield's theory is largely based on Boorse's, I will collapse my discussion of function found in both theories and deal only with Boorse's.

2. Philip Kitcher, "Species," *Philosophy of Science* 51, no. 2 (1984): 308-333.

3. Larry Wright, "Functions," *Philosophical Review* 82, no. 2 (1973): 139-168.

4. Ibid., 161.

5. Ibid., 161-162.

6. Robert E. Cummins, "Functional Analysis," *Journal of Philosophy* 72, Nov. (1975): 741-764.

7. Ibid., 765.

8. This is where Gould's theory of exaptations comes in, though I said I would not talk about it, even though I seem to be now.

9. I should mention here that Philip Kitcher has attempted to synthesize these competing concepts of function with talk of 'design', which he argues answers first the problem of evolutionary accidents that Wright's concept fails to address. Second, Kitcher's use of design focuses on a part's *relevant* capacities by exposing the 'source of design in the background' of any causal story. Suffice it to say, Kitcher's function synthesis takes us far down the intellectual road in understanding species typical functioning for use in naturalist and hybrid nosologies. (see n. 2)

10. Christopher Boorse, "On the Distinction Between Disease and Illness," *Philosophy and Public Affairs* 5, no. 1 (1975):49-68.

11. Somerhoff's and Nagel's accounts are extensions of inquiries into function concepts dealing with cybernetics in the 1950's. They are intended to show that goal directedness can be internally regulated by the animal or machine without purposefulness.

12. Christopher Boorse, "Health as a Theoretical Concept," *Philosophy of Science*, 44, No. 4 (1977): 555

13. *Ibid.*, 556.

14. Christopher Boorse. "A Rebuttal on Health," in *What is Disease*, ed. James M. Humber and Robert F. Almeder (Totowa, N.J.: Humana Press, 1997), 7.

15. K.W.M. Fulford, *Moral Theory and Medical Practice* (New York: Cambridge University Press, 1989); K.W.M. Fulford, "What is (Mental) Disease?: An Open Letter to Christopher Boorse," *Journal of Medical Ethics* 27, no. 2 (2001): 80–85.

16. Fulford, 2001, 81.

17. Ibid., 84.

18. Fulford, 1989, 127.

19. Ibid., 81.

20. Boorse, 1977, 557.

21. Derek Bolton, *What is Mental Disorder? An Essay in Philosophy, Science, and Values* (New York: Oxford University Press, 2008), 115.

22. Boorse. 1975, 63.

23. As cited by Christopher Boorse, "What a Theory of Mental Health Should Be," *Journal for the Theory of Social Behavior* 6, no. 1 (1976): 65

24. Boorse, 1976, 78.

25. In Boorse, Rebuttal. (see n. 14)

26. Joseph Margolis, *Psychotherapy & Morality* (New York: Random House, 1966); Boorse, 1975, attacks this thesis stating: "Margolis argues in his first chapter that psychoanalysts have been mistaken in holding that their therapeutic activities can 'escape moral scrutiny.' From this he concludes that 'it is reasonable to view therapeutic values as forming part of a larger system of moral values,' and explicitly endorses normativism. But this inference is a non sequitur. From the fact that the promotion of health is open to moral review, it in no way follows that health judgments are value judgments." (54)

27. Karl Popper. *Conjectures and Refutations: The Growth of Scientific Knowledge* (New York: Routledge, 2003); Popper's view of Freud's theory is not without controversy. See: Adolf Grünbaum, *The Foundations of Psychoanalysis: A Philosophical Critique.* (Berkeley, CA: University of California Press, 1984) and Adolf Grünbaum, "Is Psychoanalysis a Pseudo-science? Karl Popper versus Sigmund Freud," *Zeitschrift für philosophische Forschung*, 31, H.3 (1977): 333-353; Grünbaum's argument is that Freud's theory is falsifiable and ultimately Popper's method for distingutishing between science and pseudoscience is flawed.

28. Boorse, 1975, 66.

29. Jerome C. Wakefield, "Aristotle a Sociobiologist: The 'Function of a Human Being' Argument, Black Box Essentialism, and the Concept of Mental Disorder," *Philosophy, Psychiatry, & Psychology* 7, no. 1 (2000): 20

30. Wakefield, 1992, 378. (see ch.1, n. 32)

31. Ibid., 383.

32. In his book *Schizophrenia: The Sacred Symbol of Psychiatry* (Syracuse, NY: Syracuse University Press, 1976), Szasz states his thesis thusly, "What is schizophrenia?...The point I wish to emphasize here, right at that the outset, is that the claim that some people have a disease called schizophrenia was based not on any medical discovery but only on medical authority; that it was, in other words, the result not of empirical or scientific work, but of ethical and political decision making."(3). In a recent interview with Australian Broadcasting Corporation (April, 4 2009), when asked about the reality of the symptoms of auditory hallucinations of schizophrenia, Szasz responded that all talk of schizophrenic symptoms question-beg and that auditory hallucinations are nothing more than self-talk: "Well it's impossible to answer this kind of question because it is based on a story which already validates psychiatry. Now where is this man who is rocking back and forth in his own urine? I've never seen such a person in more than 50 years of psychiatry—where is he, how did he get there, who is he and how does a psychiatrist know that he is talking to the CIA? There is only one way he could know that, that's by the patient telling him and the patient tells you that the CIA is talking to him; let's assume if someone told me that I would tell him, well congratulations, you are a very important person. That's not against the law." (Accessed November 2009: http://www.abc.net.au/rn/allinthemind/stories/2009/2530830.htm)

33. World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research.* (Geneva: WHO, 1993).

34. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 4th ed., text rev. (Washington, DC: American Psychiatric Association, 2000).

35. Boorse, 1976, 77.

36. Ibid., 77.

37. Ibid., 77.

38. World Health Organization. ICD-10 (2007) http://apps.who.int/classifications/apps/icd/icd10online/index.htm?gf60.htm+F640 (accessed May 12, 2010)

39. George J. Agich, "Evaluative Judgment and Personality Disorder" in *Philosophical Perspectives on Psychiatric Diagnostic Classification*, ed. John Z. Sadler, Michael A. Schwartz, and Osborne P. Wiggins (Baltimore, MD: Johns Hopkins University Press, 1994), 233-245.

40. Ibid., 242.

CHAPTER 3

THE PRAGMATICS OF MENTAL DISORDER: A THEORETICAL SYNTHESIS

Introduction

In the previous two chapters, I sketched out the landscape of philosophical theories of health and disease and the central concept of function. As I have shown, the core cases of mental illness and disorder can be reasonably described in terms of both biological and social dysfunction. Further, Boorsian naturalism, notwithstanding its now well-known drawbacks, takes us surprisingly far in our description of core cases. Thus, it seems reasonable to claim – and recent data bear this out— that a core case such as schizophrenia represents an empirically measurable deviation in the statistically normal development, structure and function of the human brain.[1] Though there is still considerable controversy surrounding this point, the literature I have surveyed points to a growing consensus about the fact that schizophrenia is marked by brain lesions or developmental abnormalities, which satisfy the functional criteria of a disease, at least according to mainstream naturalists. Likewise, with depression and bipolar disorder there are substantial data to support the claim that these are instances of biological dysfunction in Boorse's sense. Thus, we can at least grant Boorsian naturalism some degree of explanatory credit for the conceptual foundations of core cases.

In contrast, personality disorders *qua* boundary cases— those kinds of mental illnesses that are currently defined either primarily or exclusively in terms of social dysfunction— remain stubbornly resistant to categorization according to naturalistic theories. As we have seen, Boorse does attempt to correlate character disorders to dysfunctions of Freudian mental apparatuses. I think it is safe to discount this approach

as being, at best, not falsifiable and, at worst, theoretically incredible. Nonetheless, it should be noted that more sophisticated research into the biological bases of personality disorders is afoot. Researchers are currently working to identify neurochemical substrates, morphological characteristics of the brain, and the genetics of personality disorders. For example, researchers have used functional MRI and positron emission tomography to examine the brains of individuals with borderline personality disorder noting differences in metabolism and structure in parts of the prefrontal lobe and limbic system.[2]

As we examine the empirical data, we must remember: all of these studies presuppose a pre-neurological set of criteria about normalcy and personality types, upon which researchers depend before they can even begin the task of identifying correlates. And despite the push for a scientifically based categorization of personality disorders, the key feature of all personality disorders, according to the DSM, remains the "enduring pattern of inner experience and behavior that deviates markedly from the expectations of the culture of the individual who exhibits it."[3] As we know, this culturally bounded definition is similarly reflected in the WHO's definition of personality disorders as, "representing extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others."[4] Thus, both diagnostic schedules recognize that personality disorders are culturally determined and that biological evidence is not, should not, and cannot be determinative of their etiology. It is thus an odd feature of both the DSM and ICD that they aspire to evidence-based categories but simultaneously cling to socially determined ones in the case of personality disorder.

As one might expect, in spite of the hopes of the APA to define personality disorders in both scientific and culturally dependent terms, there exist mainstream theories of personality within psychology and psychiatry that explicitly hold that personality disorders are not diseases at all. For example, Theodore Millon, whose substantial work in personality theory cannot be understated, holds the position that personality disorders are not diseases despite the tendency to define them as such. In his well-known text, *Personality Disorders in Modern Life,* Millon and Davis state,

> By presenting the personality disorders as entities that can be diagnosed, the DSM encourages the view that they are discrete medical diseases. They are not. The causal assumptions underlying Axis I and Axis II are simply different. Personality is the patterning of characteristics across the entire matrix of the person. Rather than being limited to a single trait, personality instead regards the total configuration of the person's characteristics: interpersonal, cognitive, psychodynamic, and biological. For the personality disorders, then causality is literally everywhere. [5]

Millon's own approach aims to capture the interplay between biological, social, and cultural forces that may instantiate as disordered personalities. His theoretical approach holds promise because it is, in a sense, pragmatically oriented in its recognition of the emergent properties of personalities, its rejection of the reductionist tendency to try to define personality disorders as biological dysfunctions (diseases), and it avoids the obvious pitfalls of Boorsian naturalism based on antiquated Freudian mechanisms.

However, Millon himself provides an unabashed naturalistic explanation in his construction of an evolutionary theory of personality. He argues that the healthy

personality *is* the one that fits with the universal (natural) goals of survival, reproduction, happiness, avoidance of pain, and adaptation. Thus, while he would reject the claim that personality disorders are reducible to biological functions, he proposes an equally nonnormative account of how personality disorders should be described. Without spending pages detailing Millon's model, suffice it to say his theory reflects the same aspirations of a naturalist such as Boorse: "The evolutionary model believes that evolution is the logical choice as a foundation for an integrated science of the person."[6] For Millon, a functional personality is part-and-parcel of what is evolutionarily advantageous. It allows for important social bonds to be formed and for the entire individual to successfully navigate complex social structures and interpersonal relationships. Moreover, a functional personality supplies the necessary skills to negotiate intrapersonal and interpersonal conflict thereby allowing the individual to eventually reproduce or advance their own fitness in some other way.

What this shows is that Millon's seemingly promising theoretical alternative to Boorsian naturalism is actually another blind alley; it returns us to the original problems that render naturalistic explanations of personality disorders insufficient. This is to say, it provides an account for the core cases of mental dysfunction but stops short of providing a truly robust account of what makes a particular personality *naturally* functional or dysfunctional. The debate about the infiltration of norms would surely ensue and we'd find ourselves back at square one.

At this point, to reiterate, we have a strategic choice to make as we figure out a better theoretical underpinning for boundary cases: (1) We can accept naturalistic theories of mental illness and wait for empirical evidence to justify our nosology of

personality disorders. This is option is taken by clinically trained scholars of philosophy of psychology and psychiatry such as Jerome Wakefield; (2) We might jettison naturalism altogether and search for a better and more widely encompassing theory—perhaps one that wholeheartedly embraces the idea that mental disorders are social constructions; (3) We could ignore boundary cases altogether as nonmedical social problems that fall outside the domain of medicine; or (4) We could expand the scope of our theory of mental disorder to include psychological-medical interventions for boundary cases as a matter of practical importance, irrespective of whether they are 'natural kinds' or 'diseases'. Again, I am taking the fourth tack. And as a reminder, in drawing the boundaries between clearer cases of mental disease and boundary cases psychological disorder exemplified by personality disorders, I wish to remain more-or-less agnostic about the ontological status of personality disorders. That is, the question of whether personality disorders are *in actuality* ontologically related to other mental illnesses such as schizophrenia will be considered less important than showing why we should treat them *as if* they are ontologically related.

Let us now examine two pragmatic theories of disease and mental illness offered by philosophers George Agich and John Banja. We will see that the move toward a more atheoretic pragmatism in psychiatric nosology is a laudable first step and is already implicit in the DSM. However, current pragmatic theories of mental illness seem to founder in two respects: (1) They do not offer a clear enough justification for distinguishing between mental illness and vice and (2) They do not provide guidance for the transparent and ethical application of the theory when categorizing constellations

behaviors. These will be the two theoretical lacunae I will attempt to fill in with my theory in the following chapters.

Agich's Pragmatic Theory of Mental Illness

Over the past 20 year, philosopher George Agich has developed one of the most developed pragmatic theories of health, disease, and illness. As mentioned above, Agich has argued that the DSM itself presents evidence of the practical and evaluative dimensions of psychiatric nosologies. Although he has been very critical of Boorse's naturalism, his concern isn't so much to refute Boorse's theory but rather to show that whatever the true nature of mental disease might be, the practical importance of categorization supersedes concerns about metaphysics. In his analysis of the diagnostic criteria of anti-social personality disorder (APD), Agich has crystallized his views thusly,

> ...my analysis does not commit me either to a rejection of psychiatric diagnosis as myth or political critique of the clinical use of the diagnosis APD. However, I do share with critics of psychiatric diagnosis and APD a belief that psychiatric diagnosis is essentially a matter of practical ethics; unlike them I accept the descriptive aspect of diagnosis and believe that nosology is an eminently practical and pragmatic exercise. My hypothesized pragmatic view of contemporary classification of psychiatric disease reinforces this point.[7]

This statement dovetails with my own intuition that the ontological status of mental disorders provides little guidance in our construction of a psychiatric nosology that meets practical and ethical muster. This is a claim I will develop in chapter 5. But now we must ask: What is it that Agich's "hypothesized pragmatic view" actually offers?

Agich first recognizes and reviews the theoretical split between naturalistic theories and theories about the sociopolitical constructions of disease. He believes both of these models of disease are unsatisfactory for understanding the nature of disease and especially the mental illness. He is, of course, more sympathetic with the normative theorists. In his 1997 critique of Boorse, Agich defends his own pragmatic theory of disease by deploying four specific arguments to show that disease is better understood in pragmatic terms that are not committed to ontological claims about species typicality or biological function.[8] His overall position turns on the basic claim that the use of the term 'disease' in ordinary language and the practice of medicine reveals that it is a pragmatic construct. The foundations of this position are fully articulated in Agich's 1983 paper, "Disease and Value: A Rejection of the Value-Neutrality Thesis."[9] It should be noted that, in his 1997 paper at least, Agich restricts his argument to assert only that disease might be considered to be a practical concept; he stops short of saying that disease ought to be considered a practical concept though he does endorse the cultivation of a more pragmatic view elsewhere.[10] I will develop this normative claim later. Let us now look at his set of arguments in more detail and consider them as a springboard for my project.

Agich's first argument about the pragmatic dimensions of the concept of disease is essentially mined from the philosophy of language combined (implicitly) with Talcott Parsons's well-known concept of the sick role. Agich states that the language of disease emerges from the very basic social need to address instances of human suffering and to assign particular roles and characteristics to mark out those people who suffer in particular ways. Thus, 'illnesses' are subjective feelings and are grounded on something more basic—a 'disease'—which makes possible a discourse about common features of

instances of individual suffering. This is important because, as Agich states, channeling Parsons, "to be sick involves implicit claims about oneself as well as claims made by others about oneself...the sick individual is relieved of some responsibilities. We allow, for example, sick leave and commonly accept sickness as an excusing condition for poor performance, because we recognize that sickness befalls individuals and diminishes or distorts their capacity for autonomous action, thought, and feeling." Moreover, it is assumed that the sick individual should want to get better and is expected to seek out and cooperate with a health care provider. The upshot, according to Agich, is that the sick role can only be filled by those people who are *truly sick*, and to be truly sick means one has a disease.

Thus, the concept of disease is simply a practical measure against which society more generally and health care providers specifically validate that a person is truly sick. In other words, disease is a tool that serves the practical purpose of categorizing people who should receive medical attention versus those who might need some other form of support (or none at all). In responding to Boorse, Agich further claims that, "the goal of scientifically explaining disease in terms of causal laws is thus not a free floating intention, but is ultimately grounded in a historically mediated response to the universal human experience of illness and sickness." [11] This argument complements and reiterates Engelhardt's brand of strong normativism, by pointing to the intrinsic evaluative elements within the language of medicine.[12]

Agich's next broad claim is that even the most objectively oriented or "science-based" theories of disease, illness, and health are permeated with values. Indeed, even granting the possibility that Boorse's theory of disease seems nonnormative, Agich notes

that nothing comes of that theory—in practice—until values are brought to bear on the disease transforming it into an illness. Agich notes that Wakefield rightly sees the integral part played by values in his harmful-dysfunction theory of disorder. But on both counts, Agich argues that disease and function claims are contaminated with values. In agreement with Fulford, Agich thinks that the so-called "science-based" descriptive claims of function are actually commingled with evaluative language and are camouflaged in our ordinary language as objective terminology. He states that,

> Some value terms can have predominantly descriptive connotations in contexts in which the descriptive criteria for the value judgments that they express are largely settled or agreed on. Where convention or social agreement exists, value terms can be accepted as descriptions, but whenever disagreement occurs, the descriptive content tends to fall away and we are left with disputed evaluative content. [13]

To illustrate this point, Agich, citing Fulford, offers the example of physical pain, which is generally considered an 'evil' that most people avoid. Of course, there are individuals who seek out physical pain because they find it pleasurable. However, these people are, it seems, few and far between in relation to those who wish to avoid physical pain. In contrast, there is less of a consensus about the nature and desirability of particular mental 'pains' such as anxiety or melancholy. Thus, Agich believes that since many people seek out anxiety-inducing situations for the "thrill of fear" it is no wonder that "mental illness in which anxiety plays an important part will appear to be more value laden and hence more controversial than physical illnesses caused by pain." [14] His point, quite simply, is

that the terms we consider to be reflections of natural kinds are simply the ones to which we are accustomed.

Agich continues by arguing that a pragmatic theory of disease has several advantages over other kinds of theories. He claims first that understanding disease in practical terms "encourages a historically and socially situated analysis of the construction and use of disease concepts." [15] For Agich, the key advantage of the pragmatic model is that it is "self-critical", meaning that pragmatists for disease are forced to grapple with the specific contexts of the concepts they espouse. In the case of mental illness, they must offer justifications for their use of disease and illness terms in each instance in question, thereby making explicit the values that might be brought to bear on a particular set of behaviors. The touchstones of a philosophically coherent pragmatic theory of disease will account for the main purposes of the concept of disease: to care, cure, control and communicate. Without delving into Agich's explanation of each dimension, suffice it to say in each case a pragmatic theory of disease allows for a clearly articulated justification or enhanced ability to achieve these goals.

Indeed, as Agich has argued, the current and previous editions of the DSM have been implicitly pragmatic in the way they grapple with these goals. This should not come as a surprise to those who know a bit of the political history of the DSMs such as the now-infamous controversy about homosexuality.[16] Agich claims (in relation to the third edition) the DSM presents a series of contrary tendencies—to be both scientifically "objective" while also accommodating a clear need to categorize particular disorders that are only socially and contextually defined. He points out that the DSM-III promised to describe mental illness in terms of "behavioral, psychological, and biological

dysfunction" and that the multiaxial framework, which premiered in that edition, offered a biopsychosocial framework for characterizing mental illnesses.

In their analysis of the process of developing diagnostic frameworks, Sadler, Hulgus, and Agich mount a vigorous challenge to Robert Spitzer's defense of the DSM's scientific validity. They did this initially in a 1994 paper, wherein, among other things they argue that under Spitzer's lead, the DSM working groups had not properly acknowledged the values and pragmatic bargains being made during the development process.[17] They argue that the DSM working groups do often offer a set of validated methods for assessing mental disorders but that these methods are often compromised or substituted for more practical models of diagnosis. As a case in point, they argue that the dimensional model of diagnosis—which tracks the clinician's estimate of severity—and the categorical method of diagnosis are nothing more than pragmatic artifacts. They say:

> Another example of conflict between values of scientific rigor and practical (clinical) utility is the DSM-IV era considerations of dimensional versus categorical personality diagnosis (PD). It is significant that someone as resolutely "pro" DSM as Thomas Widiger recognizes that the science supporting dimensional formulations of personality and personality disorders is stronger than the science supporting the categorical diagnosis for PDs. A practical consideration for PD diagnosis is that clinicians don't find personality dimensions a familiar and useful way of conceptualizing patients. This conflict between scientific values and practical ones was evident in DSM-IV deliberations.[18]

Similarly, the DSM-III stipulated "there is no assumption that each mental disorder is a discrete entity with sharp boundaries between it and other mental disorders, or between it and no mental disorder."[19] Yet, the differential diagnosis method parses manifestations of potential mental illness by first filtering them through biological criteria. The larger structure of the DSM prioritizes those categories that can be grounded on specific organic causes and diagnosis should begin with consideration of conditions with established biological bases. For example, for patients with both schizophrenia and dysthymia, schizophrenia should be diagnosed as the primary diagnosis. Despite this prioritization in diagnosis, as Sadler, Hulgus, and Agich have pointed out with regard to the DSM-III, the development of a more robust genetic nosology of schizophrenia might have been developed but was traded-off for more traditional, clinically useful, and less scientifically valid models for diagnosis.[20] Likewise, Sadler, Hulgus, and Agich challenge Spitzer's reasoning for the elimination of terms like 'neurosis' and his willingness to forego compatibility with the ICD as instances of practical considerations overrode scientifically based ones.[21]

In his 2001 response to their 1994 paper, Spitzer rejects the claims of Sadler, et al. arguing that their interpretation of the development process of the DSM has been misguided. Spitzer acknowledges that the development of the DSM is a deeply value-laden and political enterprise. He should know: it was under his leadership that homosexuality was redacted from the DSM. However, Spitzer claims, the DSM task force members were under no impression that they were working in a 'value free' way. According to Spitzer, the claim made by Sadler, et al. that the DSM was naive about the values being used to make classification decisions was simply false. Moreover, Sadler, et

al. misunderstand the meaning of psychological validity—in the context of the DSM, validation is meant as a means to back up the overall description of the disorder category. Validation information may include, "etiology, risk factors, usual course of the illness, whether it is more common among family members, and most important, whether it helps in decisions about management and treatment."[22] Sadler, et al. also misunderstand how validation and reliability are related. They argue in the DSM there was a conflict between these concepts. But according to Spitzer, the goals of both validation and reliability are not in conflict, but rather complementary, with reliability adding an additional undergirding to a valid mental disorder. Spitzer says, "Although a diagnosis can be reliable but have no validity, unreliability provides an upper limit to the validity of a diagnosis."[23]

Spitzer responds to several other points of contention related to the pragmatics of the DSM, concluding that really, in the end, the most significant source of conflict was not in values arguments about particular diagnoses, but rather the conflict within the field itself. For example, psychodynamic practitioners felt as though their particular approaches and methods were threatened and devalued by the new DSM. Ultimately however, for Spitzer, there was no doubt that values had infiltrated the classification process—it would have been silly to think they would not. Moreover, there was a robust literature that examined and explained these values and tradeoffs throughout the revision process.

Nonetheless, we can revisit similar questions about the DSM-V raised by Sadler, et al. Are these same pragmatic assumptions and trade-offs operational in the current development of the DSM-V? Such a question is even more pressing because the task

force leading the creation of the next edition promises to expand the "scientific basis for psychiatric diagnosis and classification."[24] This will entail marshalling evidence from genetics, molecular biology, and neuroscience and using those data as touchstones for a new set of diagnostic categories. It would seem that pragmatic tradeoffs that riddled the DSM-III process would be less likely to occur or, at the very least, be discouraged. Regardless, a continued appeal to practical criteria shapes the definitions of personality disorders, which can be seen in the preview of the DSM-V. The current proposals state that personality disorders will be defined as variances within the larger personality "domain," which will be defined according to five dimensions:

> 1) an overall rating of personality (self and interpersonal) functioning ranging from normal to severely impaired
>
> 2) prototype descriptions of major personality (disorder) types
>
> 3) personality trait assessment, on which the prototypes are based, but which can also be used to describe major personality characteristics of patients who either do not have a personality disorder or have a personality disorder that does not conform to one of the prototypes
>
> 4) generic criteria for personality disorder consisting of severe deficits in self differentiation and integration and in the capacity for interpersonal relatedness
>
> 5) measures of adaptive functioning.

Taking special note of dimensions 2 and 3, we see a prototype analysis, which, as will be discussed below, is a method of grouping that relies upon the sampler's experience with many similar cases. Moreover, the new categories will be established based on the goal

of providing clinical treatment—a goal that begs the central questions of what it is that should be or is being treated.

We might also acknowledge Spitzer's very reasonable rejoinders but also argue that to the extent there are conflicting messages within the manual itself, and in the process related to developing new categories of personality disorders, the use of a pragmatic methodology is generally *ad hoc*. A well-developed pragmatic theory of mental illness should have the resources to deal with this problem in a systematic way. For example, Agich's theory demands a level of self-reflectiveness that is continually critical of the products of its classification. This is to say that Agich's main focus is on offering a theory that allows for analytic honesty among those engaged in the classification effort—such as those on the APA DSM working groups—about their possibly unspoken goals and the consequences of their taxonomies. Likewise, Sadler, et al. argue that a more explicit recognition of values in the DSM will lead to an understanding that "value choices, conflicts, and commitments have had a significant, indeed essential, role in the shaping the DSM...explicit attention to...*values* in DSM will contribute to a more self-reflective, fair-minded, and responsive nosological process...values have been broadly involved in the nosological choices reflected in the DSMs, and their analysis and discussion should become a central part of future DSM processes." [25] This call for nosological value-transparency is a crucial point to keep in mind as we move forward.

Some might argue that the process of developing the new DSM is proceeding in a way that is open to public and professional comment and is transparent. This claim is true to an extent. The DSM-V working groups have posted all of their deliberations,

research, and proposals to a publically accessible website. Likewise, there is a mechanism in place for public and professional feedback on all proposals developed by each work group. However helpful these commenting tools might be, Agich suggests that a deeper examination of value-based choices must permeate all of the deliberations on new categories or reformulations of categories. He argues with Sadler that "a humane revealing of the ambiguities, assumptions, value commitments, and omissions intrinsic to the nosologic enterprise" must be revealed and analyzed. Invoking the insights of social and political philosopher of science Helen Longino, Sadler and Agich demand more than simply procedural transparency:

> Through revealing these commitments a social, intersubjective process of critical evaluation is demonstrated. This social process (debate, both professional and public) is the means to assure a reasonable balance of competing values and, indeed scientific objectivity. Not a naïve realist objectivity, to be sure, but an objectivity established through intersubjective agreement and validation, and characterized by an awareness of the competing social and historical interests that too-often invisibly determine scientific results and "progress". It is this revealing of sociohistorical value commitments that is the important role of philosophical analysis in science as well as critical analysis of psychiatric nosology.[26]

As I present my own proposal on how to achieve these theoretical conditions, I will characterize their demands for a sophisticated and intersubjective form of scientific

objectivity as being synonymous with a sophisticated nosological pragmatism that includes several ethical components.

Unfortunately, neither Agich nor his colleagues go very far in developing these ethical theoretical demands and dimensions. It is true Agich had previously and correctly recognized that nosological construction and psychiatric diagnosis are a matters of practical ethics, but this insight is downplayed as a central feature of his pragmatic theory (at least as it is articulated in his 1997 paper). [27] As I will argue, in making transparent the practical goals of the classification of mental illnesses not only will a more philosophically coherent nosology be made possible, but also a more ethically defensible classificatory scheme can be developed. Thus, one of the most important consequences of an explicitly pragmatic nosology of mental illness will be that it will demand more transparency about the social and political values and the historical or traditional expectations that may drive the classification of a particular constellation of behaviors as a mental illness (or not).

Banja's Pragmatic Theory

In a paper published adjacent to Agich's 1997 commentary on Boorse, John Banja makes the stronger claim that "disease" is not even definable.[28] Instead, for Banja, the concept of disease is an umbrella term that "embraces a number of clinical entities or conditions that are related."[29] The wide and fuzzy-edged penumbra of 'disease' casts over large swaths of socially recognized behaviors, making them worthy or deserving of medical attention. Banja, therefore, argues that disease is better understood and explained according to Rorty's concept of a "web of beliefs" or Wittgenstein's notion of family resemblance. This is to say, the question of whether something is a disease or not

depends on the context within which this question occurs and not on some essentialistic quality that refers to a discrete reality.

Banja points to Rorty's insight that any attempt to develop a correspondence theory of reality is impossible to achieve without taking a God's eye view of that particular reality—a perspective that is impossible to achieve. Similarly, Banja, citing neuroscientist Mark Johnson, argues that our understanding of core concepts such as disease turn on our knowledge of semantic prototypes. Thus, according to Banja, our understanding of diseases is not definable by a set of necessary and sufficient conditions. Rather our understanding is governed by experiences with an amalgam of prototypical members of the category. Moreover, social value is prior to the concept of disease in that it motivates the investigation into physiological events of interest: "Diseases do not share an essence, but rather form a family, loosely associated by certain pathophysiologic events expressing themselves as signs and symptoms that a particular society deems undesirable."

As Wittgenstein famously argued, we can recognize diverse activities such as poker, baseball, or Olympic curling as belonging to the same family (*game*) because they resemble one another in various and particular ways. However no one criterion can be found to define the concept of game; thus game is a blurry concept. Wittgenstein goes on to say that a game is a concept with blurry edges, but is good enough in our common use of language to provide what is needed. Consider the set: atherosclerosis, HIV/AIDS, bipolar disease, infertility, and post-traumatic stress disorder. It would be difficult to articulate a common characteristic that makes all these diseases. One might be tempted to claim they are all *bad* things. But infertility might be a good thing to a person who is

not interested in having children. Likewise, we might want to claim they are all frustrations of species typical functioning. But, in the case of PTSD, this explanation relies on empirical evidence that it is maladaptive to exhibit stress responses after a traumatic experience. One could as easily argue from an evolutionary perspective that it is adaptive to be on heightened alert to threats, especially after experiencing such threats, and that PTSD is a natural artifact of this adaptation.

The Wittgensteinian point, endorsed by Banja, is that discovering a shared set of necessary and sufficient conditions for "diseaseness" is impossible. We should accept the fact that no one essential characteristic is shared across an array of conditions we consider to be diseases. Banja argues that this is okay. Family resemblance is the best we can do. Thus, we should settle on the nosological concepts that have the most pragmatic value based on partial overlap of sets of characteristics, despite their blurry edges. This general approach is reflected in a similar theory developed by Sadegh-Zadeh (2008), who describes his approach as an attempt to reconcile the current stalemate between classical concepts (essentialism) with the nonclassical reality of psychiatric disorder. [30] Like Wittgenstein, Sadegh-Zadeh thinks that mental illnesses are not natural kinds and psychiatric disorder should be considered "fuzzy sets" which are "a collection of objects with grades of membership. In contrast to a classical set, it does not have sharp boundaries between members and nonmembers." [31]

With Agich's and Banja's pragmatic theories now sketched, we are encouraged to think of mental illness not in terms of essences, but rather in terms of clusters of phenomena that are related in the way they manifest in the language and the practice of medicine. Their theories provide us with guidance on the practical markers that should

be recognized in the development of an adequate classification system. However, both theories provide little guidance about the ethical dimensions of diagnosis and classification of mental illness. Developing an ethical account of how the pragmatic theory *ought to be applied* is what we must do next.

Identifying Theoretical Gaps

So far we have seen that Agich's pragmatic theory offers resources to both account for and refine the pragmatic assumptions that are part and parcel to the language of medicine and arguable built into the DSM. Similarly, Banja's pragmatic theory emphasizes the importance of medical practice in understand its core concept. As we now also see, underneath both Agich's and Banja's pragmatic theories rest a set of pretheoretical notions about what diseases is. And although both pragmatists would resist the question about the true nature of diseases, which takes us back into metaphysical territory, an understanding of these commitments is important in developing an ethically defensible pragmatic theory. This is to say that the ontological status of mental illness is in some sense bound up with how we ethically deal with it in practice. For both Agich and Banja, disease is a "practical kind" that should be defined in terms of what that concept offers toward the goal of relieving human suffering.[32]

Although aforementioned pragmatic theories of mental illness do a nice job of describing their "ontological" commitments, they do not offer any normative content to help us determine how they should be applied. Let us now begin our synthesis of these theories with what I believe are several crucial ethical components that will fill in the normative gaps. I will sketch these ethical components here and then detail them in chapters 4 and 5.

First, current pragmatic theories of mental illness fall short because they fail to clearly distinguish between the concepts of mental disorder and moral vice. This deficiency might be understood as a failure to provide a framework for the proper scope of the theory. Neither Agich's nor Banja's pragmatic offerings provide any internal guidance for the appropriate application of the theory to a constellation of questionable behaviors and thus we are left questioning which instances of socially dysfunctional behaviors are better considered to be vice, mental illness, or both. Thus, these theories lack the key components to test whether a constellation of socially dysfunctional behaviors should be medicalized and therefore included within the domain of psychiatry or treated as social problems that should be delegated to other professionals or, more likely, simply left completely untouched.

Related to this deficiency are several other missing normative components of a comprehensive pragmatic theory of mental illness. These components rely on a set of undeveloped ethical subtheories, which would help provide the necessary value judgments about what should fall within the domain of the pragmatic nosology. I envision these missing normative components as operating at several interdependent levels of psychiatric practice. First, they would serve as a guide for individual practitioners to navigate the ethical straits of psychiatric diagnosis. Therefore, this ethical dimension of the pragmatic theory will provide a description of several core virtues of individual practitioners who are charged with the diagnosis of patients. A second new theoretical component would provide an ethical framework to classification task forces and working groups. At this more macroscopic level, a comprehensive pragmatic theory will make ethical demands on the professional bodies within psychiatry and psychology

that are tasked with developing the classification criteria and diagnostic categories. Third, the components of an ethically robust theory of mental illness will be informed politically in that they should provide insight into the power structures that are at work in the development and deployment of pragmatic inclusion of behaviors in the psychiatry nosology. Finally, a robust pragmatic theory of mental disorder should also have a strong historical component, which supports and complements the political subtheory, such that nosologists are keenly aware of the past uses (and abuses) of medical diagnosis. Let us now begin to unpack these various components of our new pragmatic theory and then, in Chapter 6, provide a casuistry of how they unfold in providing both explanation and guidance to actual cases of psychiatric diagnosis of boundary cases.

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1. There is a plethora of studies on brain morphology and schizophrenia. See for example: R.M. Shapiro, "Regional Neuropathology in Schizophrenia: Where Are We? Where Are We Going?" *Schizophrenia Research* 10, no. 3 (1993): 187-239; Natalie L. Voets, Morgan Hough, Gwenaelle Douaud, Paul M. Matthews, Anthony James, Louise Winmill, Paula Webster, Stephen Smith, "Evidence for Abnormalities of Cortical Development in Adolescent-onset Schizophrenia," *NeuroImage* 43 no.4 (2008): 665-675.

2. Andrew E. Skodol, Larry J. Siever, W. John Livesley, John G. Gunderson, Bruce Pfohl, Thomas A. Widiger, "The Borderline Diagnosis II: Biology, Genetics, and Clinical Course," *Biological Psychiatry* 51, no. 12 (2002): 951-963; F.D. Juengling, C. Schmahl, B. Heßlinger, D. Ebert, J.D. Bremner, J. Gostomzyk, M. Bohus, K. Lieb, "Positron Emission Tomography in Female Patients with Borderline Personality Disorder," *Journal of Psychiatric Research* 37, no. 2 (2003):109–115.

3. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 4th ed., text rev. (Washington, DC: American Psychiatric Press, 2000).

4. World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research* (Geneva: WHO, 1993).

5. Theodore Millon and Roger Davis, *Personality Disorders in Modern Life* (New York: Wiley, 2000), 9-10.

6. Ibid., 68.

7. George J. Agich, "Evaluative Judgment and Personality Disorder," in *Philosophical Perspectives on Psychiatric Diagnostic Classification*, ed. John Z. Sadler, Osborne P. Wiggins, and Michael A. Schwartz (Baltimore, MD: Johns Hopkins University Press, 1994), 244.

8. George J. Agich, "Toward a Pragmatic Theory of Disease in Humber," in *What is Disease?*, ed. James M. Humber and Robert F. Almeder (Totowa, NJ: Humana Press, 1997), 221-246.

9. George J. Agich, "Disease and Value: A Rejection of the Value-Neutrality Thesis," *Theoretical Medicine* 4, no. 1 (1983): 27-41.

10. George J. Agich, 1994.; John Z. Sadler, George J. Agich, "Diseases, Functions, and Psychiatric Classification," *Philosophy, Psychiatry, and Psychology*. 2, no. 3 (1995):219-231.

11. Agich, 1997, 226.

12. As detailed in Chapter 1, I am using the terms 'normativist' and 'strong normativist' to describe those theorists who argue the concepts of health, disease, and illness are value-laden. Agich, in contrast, uses this same term to refer to theorists whose theories aim to distinguish between value-neutral functions and social values, such as Boorse, Wakefield and Szasz.

13. Agich, 1997, 235.

14. Ibid., 235.

15. Ibid., 237.

16. For a clearly written account of this case see Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis* (Princeton, NJ: Princeton University Press, 1987).

17. John Z. Sadler, Yosaf F. Hulgus, and George J. Agich, "On Values in Recent American Psychiatric Classification," *Journal of Medicine and Philosophy* 19, no. 3 (1994): 261–277.

18. John Z. Sadler, Yosaf F. Hulgus, George J. Agich, "Hindsight, Foresight, and Having it Both Ways: A Rejoinder to R.L. Spitzer," *The Journal of Nervous and Mental Disease* 189, no. 8 (2001): 495.

19. American Psychiatric Association. 1987. p.xxii as cited by George J. Agich, "Evaluative Judgment and Personality Disorder," in *Philosophical Perspectives on Psychiatric Diagnostic Classification,* ed. John Z. Sadler, Michael A. Schwartz, M., and Osborne P. Wiggins, (Baltimore, MD: Johns Hopkins University Press, 1994), 235.

20. Sadler, et al., 2001, 495.

21. Ibid., 494.

22. Robert L. Spitzer, M.D. "Values and Assumptions in the Development of DSM-III and DSM-III-R: An Insider's Perspective and a Belated Response to Sadler, Hulgus, and Agich's 'On Values in Recent American Psychiatric Classification'," *The Journal of Nervous and Mental Disease* 189, no. 6 (2001): 353.

23. Ibid., 354.

24. American Psychiatric Association. DSM-V: The Future Manual. http://www.psych.org/MainMenu/Research/DSMIV/ DSMV.aspx (accessed March 2010)

25. Sadler, et al., 2001, 496.

26. Sadler and Agich, 1995, 229.

27. Agich, 1997, 1994.

28. John D. Banja, "Defining Disease: Praxis Makes Perfect," in *What is Disease?* ed. James M. Humber and Robert F. Almeder (Totowa, NJ: Humana Press, 1997), 249-268.

29. Ibid., 251.

30. Kazem Sadegh-Zadeh, "The Prototype Resemblance Theory of Disease," *Journal of Medicine and Philosophy* 33, no. 2 (2008): 106-139.

31. Ibid., 121.

32. For an in-depth discussion of practical kinds see: Peter Zachar, "The Practical Kinds Model as a Pragmatist Theory of Classification," *Philosophy, Psychiatry, & Psychology* 9, no. 3 (2002): 219-227; Ian Hacking, *The Social Construction of What?* (Cambridge, MA.: Harvard University Press, 1999).

CHAPTER 4

A PRAGMATIC THEORY OF PERSONALITY DISORDER

Introduction

In this chapter, I propose what I take to be the key distinctions of a comprehensive pragmatic theory of mental disorder. As I have argued, current pragmatic approaches to both defining and understanding mental illness have provided a valuable starting point. They move us beyond the limitations of restrictive theoretical approaches that often conflict with our day-to-day intuitions about mental illness and disorder. Moreover, they aim to expose the norms, biases, and practical trade-offs that have been a part of the classification process itself. Also, as I described in the previous chapter, both Agich's and Banja's theories offer several resources that, when used in combination with naturalistic theories of mental illness, can provide a coherent pragmatic metatheory of mental illness and for, in particular, those cases which are the subjects of this dissertation—personality disorders.

Notwithstanding these advantages, current pragmatic theories of mental disorder do not offer the resources to make the important ethical choices about what kinds of behavioral signs should be viewed as potential mental disorders in the first place. Additionally, as we have just seen, past editions of the DSM and the future DSM-V offer definitions of mental disorder that are explicitly pragmatic. Current pragmatic theories of mental disorder are ill-equipped to provide a robust ethical analysis of the codebook's pragmatism. For example, in addressing the ascription of the label "mental disorder" and the development of new diagnostic categories, the DSM-V draft definition of mental

disorder, released during the writing of this dissertation, includes several "considerations" including the following:

> When considering whether to add a mental/psychiatric condition to the nomenclature, or delete a mental/psychiatric condition from the nomenclature, potential benefits (for example, provide better patient care, stimulate new research) should outweigh potential harms (for example, hurt particular individuals, be subject to misuse)[1]

We should note that it is unclear whether this particular consideration (or the others listed) should be viewed as a necessary or sufficient condition for adding or deleting a condition in the DSM-V. It is unlikely that satisfying this practical consideration would be sufficient for expanding or contracting the nosology; if it were sufficient, the range of possibilities for inclusion in the DSM would be incredibly broad. When understood as a necessary condition, however, this consideration offers a simple test for proposals to expand or contract psychiatric nosology. It is clear that the trade-off described in the statement is explicitly pragmatic and utilitarian. The consideration also implicitly accepts the notion that there may be good reasons for the medicalization of particular behaviors, which may or may not be directly linked to biological dysfunction and, as such, are not core cases of mental dysfunction. Conversely, the consideration suggests that particular behaviors should be overlooked even if a compelling case can be made they are mental disorders. Such would be the case in instances when the ascription of mental disorder would cause more harm than good because it would be vulnerable to abuse or the negative consequences of the stigma, which would be worse than the suspected mental disorder itself.

While I agree with the spirit of this consideration, it raises several fundamental questions such as:

- By which specific criteria shall we ascribe the label of mental disorder to a particular 'constellation of behaviors'?
- How might we 'unitize' or reify constellations of behaviors without begging the central question of whether those behaviors are disordered or not?
- How might we identify the behaviors that will constitute a 'mental/psychiatric condition' versus instances of moral failing, vice, criminality or social problems?
- How might the process of ascription proceed in an ethically justifiable way (i.e. what are the ethical requirements for the pragmatic ascription of mental disorder)?
- And, finally, how can we prospectively estimate the various harms and benefits resulting from the ascription of mental disorder or its demedicalization?

All of these questions require a more comprehensive pragmatic theoretical underpinning, which I will begin to describe in this chapter.

In order to distinguish between pragmatically defined instances of mental disorder and other kinds of behaviors, we need to first decide how to recognize and define the "units of behavior" in question. I have been referring to these as "constellations of behaviors of concern" or simply "constellations of behavior." To more carefully identify and describe constellations of behaviors that will be subjects of my pragmatic theory, I will triangulate between the following: (1) the identification of a specific form of mental

suffering, (2) a recognition that the end of medicine is the relief of this specific form of suffering experienced by patients and that this goal should also include protecting other people from the suffering caused by the disorder, and (3) deciphering the habits that might cause such suffering as a way to understand, classify, and alleviate the suffering. Since a complex web of habits composes personality disorders, I will describe how particular suffering-causing habits hang together within the larger unit of disordered behavior. I begin to illustrate these behaviors with brief case vignettes.

I will then turn my attention to an examination of the distinction between vice and mental disorder. This task is crucial so that the pragmatic theory is not so broad that it includes behaviors that are better understood as simply vicious or immoral. One commonsensical way to distinguish between vices and mental disorder is to examine a person's capacity for both self-control and capacity for free choice. In short, when dysfunctional actions are taken "freely" they are to be considered vicious, while those taken by individuals with compromised capacity or autonomy are indicative of disordered behavior. However, as I will argue, taking this tack to answer what is essentially a question about free will shall prove to be less fruitful than one might initially imagine.

My alternative claim will run along the same philosophical tracks as William James's and other pragmatist's responses to questions related to determinism and free will. Thus, I will aim to move beyond these standard philosophical poles to show the practical advantages of shifting our attention away from traditional theoretical concerns toward verifiable and predictable positive results of inclusion or exclusion of behavioral constellations within a pragmatic nosology. I hope to show that the distinction between vice and mental illness will have less to do with assigning blame or any purported

essential differences between the two concepts, but will instead rely on the "cash value"—to use James's terminology—of defining our nosological categories differently. This payout will, in turn, depend on the medicine's potential capacity to minimize suffering in the cases in question. Likewise, the same pragmatic judgment must, by the same token, consider the potential harms of shifting behaviors from what might be better perceived as part of the domain of personal responsibility. A more precise balancing of the harms and benefits associated with blame and exculpation is an essential feature of the ethical-pragmatic nosology I am proposing. Such a balancing act, we will see, requires an accurate accounting of the harms and benefits that might be ascertained through ongoing empirical investigation in both the social and natural sciences.

My third broad theoretical concern, which I postpone until Chapter 5, will be to articulate a set of ethical-pragmatic principles and key virtues that will empower both individual mental health professionals and professional groups to more fully comprehend the ethical implications of their diagnoses and categories. To do this, I will propose a set of important ethical criteria that should be in place to guide diagnosis and classification efforts. These criteria will help to cordon off mental illnesses from social problems more generally, but also ensure that medicalization of questionable behavioral constellations happens for the right reasons. Of course, defining and defending what I mean by "medicalization for the right reasons" will take some time and will be illustrated in case studies and policy proposals in chapters to follow.

Vignettes

Before turning to the theoretical underpinnings of a pragmatic approach to categorizing personality disorders, let us begin with two case narratives. Hopefully these will serve to provide empirical (albeit anecdotal) anchors for the philosophical arguments that I will offer in this and following chapters. These vignettes are culled from both popular and academic sources and provide a glimpse into the world of people diagnosed with Cluster B personality disorders—a broad category that includes "dramatic, emotional or erratic disorders." [2] There are four Cluster B personality disorders: antisocial, histrionic, narcissistic, and borderline. The stories begin to illustrate several common behavioral features and dysfunctional interpersonal dynamics that often accompany borderline personality disorder.

Laura (diagnosed with borderline personality disorder)

> When my two-year-old wants something, she wants it now. When I am shopping I can't tell myself *no*, so I buy it, even though I'm in debt. To a child, the most important thing is security and safety. For me, safety means being what others want me to be so they won't reject me. The inside stays hidden—even to me. But under all the politeness hides an angry, frightened toddler. My husband wants the damaged little girl inside me to set priorities by saying, "Yes, I'm angry, but when I talk to you I'm going to try to be reasonable." You wouldn't ask that from a real two-year-old, so don't ask that from me, either. It's not that I don't want to. I just can't.

Jacqueline (diagnosed with borderline personality disorder)

Anthony, an intern who had just gotten married, describes a conversation with his wife, Jacqueline when he announced he was going for a run: "I am off, darling," I told Jacqueline, who lay burrowed in her duvet. "Where to?" she asked. "For a run. Look at this, I am getting fat." I wobbled my gut in front of her, laughing. "So what?" "What do you mean?" "So what if you're getting fat?" "I need to lose some weight." "Who are you trying to impress?" "Nobody, it's just a healthy thing to do. Anyway, my pants are getting tight" "What's wrong with all you men? You think that you have to have rock hard bodies to get the chicks. That's not what women want. That's not what I want. I want you to take care of me. I want you to make so much money that I never have to work, and that we can go to restaurants whenever we want. I don't want some pansy prancing around in his tights." "What's gotten into you? This isn't some vanity trip. I'm just going for a run." "So it is more important to you to go for a run than to be with me?" "What are you talking about? I am with you. I'll be back in half an hour" Jacqueline took a half-empty wineglass from the nightstand and smashed it to the ground. "What the hell are you doing to me? You promised me that you would never leave." I shuddered and stepped back from her. She started to cry. "You are doing that now. You promised that you would never leave me." I went to hold her.

In both vignettes, we see several features common among patients with borderline personality disorder, including impaired impulse control, intense anger, a frantic reaction to the perception that they will be soon abandoned and an arrested sense of personal identity. We also find reflections of the inter- and intra-personal strife and alienation that seems to emerge from pervasive patterns of dramatic, petulant behavior and emotional lability. With Jacqueline, for example, we see the characteristically hostile, angry, and aggressive behavior that leaves Anthony perplexed and doubting his own intentions. In fact, this is a common feature of borderline disorder whereby friends and family are left wondering what they might have done wrong and if there is some truth to degrading claims made by their borderline relative. Compounding the confusion, these behavioral patterns seem to straddle the line of intentional and unintentional, have been described as habitual coping devices borne out of childhood abuse or neglect, and are both self-destructive and have a profoundly negative impact on others. As I will argue below, each instance of habit marks an individual point from which the larger constellations of behavior begin to take shape. Though, as we shall see in chapters 6 & 7, a deeper examination of cases such as these may reveal particular biases or gendered presuppositions about normalcy that problematize our analysis, let us keep these cases in mind as we begin to think about how our pragmatic theory of mental disorder should account for these patterns of behavior.

It is important to also consider, although not explicitly illustrated in the vignettes, the particular form of pain that sufferers of personality disorders experience. For example, studies on the subjective experience of their pain reveal that borderlines tend to experience a cluster of dysphoric states rooted in extreme feelings, self-destructiveness,

fragmentation, 'identitylessness' and victimization.[3] In the case of Laura, we might surmise that her pain is the result of a deep sense of vulnerability—she is unable to feel secure as an adult and retreats back into the vulnerable role of a child. Likewise, with Jacqueline, her suffering seems to be rooted in an all-pervasive fear of abandonment. Depending on the one's psychological orientation, Laura's and Jacqueline's behavior might be framed in terms of a distortion in object relations, splitting or identity diffusion (psychoanalytic), a fundamentally flawed schema causing irrational self-talk (cognitive-behavioral) or an imbalance of neurotransmitters (neuropsychology).

To more fully examine these concepts, let us look first at these behaviors through the lens of the unique form of suffering they might cause. In doing so, I hope to then be able to argue that this is a form of suffering that psychiatry is appropriately equipped to relieve.

Suffering & the Ends of Medicine

In chapter 2, we saw that social dysfunction is part and parcel of a personality disorder and can be thought of as analogous to the biological dysfunction concepts of naturalists like Boorse. Although brief and anecdotal, it is reasonable to suggest that the above vignettes illustrate there is *something* dysfunctional in the behavior of the antagonists, especially when we assume these short narratives are a mere snapshot of a larger pattern. A challenge in cases of social dysfunction is first pinpointing the behaviors (or cognitions, which for our purposes will be considered behaviors of thought) that constitute said dysfunction. It is much easier, for example, to observe a hole in a chamber of the heart and identify the dysfunction of the organ. To critically examine a

dysfunction in patterns of behaviors we must decompose the constellation of behaviors that seem intuitively to be dysfunctional ones, which coalesce to form the complex kind of social dysfunction constituting personality disorders.

Let us, therefore, first consider a constellation of behaviors as circumscribed by a particular set of habits—to be described below as our working 'unit' of behavior—that cause a particular kind of *suffering*. Thus, the constellations of behaviors we are most interested in are those that cause suffering or anguish that is unique in some way to other kinds of suffering. As we will see, this suffering might be experienced by the individual exhibiting the behavior, their family, the community, all of them or just a subset of them. Although physicians are concerned with the suffering of individual patients, we can understand personality disorders through the lens of public health, since others who are close to the patient experience their ill effects. Moreover, the form of suffering to which I am referring may be exacerbated by social, political and economic conditions. Thus, the ways in which what Arthur Kleinman calls "social suffering" might instantiate and be experienced is varied and diverse. In thinking about the form of suffering caused by mental disorder we must remember, as Kleinman and Kleinman argue, suffering is a social experience, which we should avoid "essentializing, naturalizing, or sentimentalizing. There is no single way to suffer; there is no timeless or spaceless universal shape to suffering."[4]

That being said, the theory I am proposing could not simply attend to behaviors that cause any and all forms of suffering. For example, we would not consider the "suffering" many of us experience while waiting impatiently in a traffic jam at the end of a long workday as the kind of suffering that matters for our analysis. This form of

suffering should intuitively strike us as being, in general, outside our domain of inquiry. While it is unpleasant, it would not be the form of discomfort that should be a candidate for medical intervention.[5] Similarly, the kind of suffering caused by particular misfortunes such as driving an unreliable car or living in a house with a leaky roof is outside the domain of medicine. It is simply not a doctor's job nor is it within her area of competence to repair your car or fix your roof.

In contrast, for example, we will want to attend to the kinds of mental or emotional anguish that accompany episodes of depression. This kind of suffering can be palliated by several kinds of medical modalities such as Prozac and psychotherapy.[6] There are certainly potential nonmedical remedies such as stress reduction workshops or a long vacation in a warm place. But the fact that medicine offers curative resources as possibly more efficacious alternatives satisfies the necessary condition that we are dealing with a form of suffering that might be rightly considered a medical disorder. Meeting this necessary condition provides the starting point for supporting the claim that conditions similar to depression should fall within the domain of medical disorder.

The capacity of medicine to relieve distinct forms of suffering is a necessary, though not sufficient, condition for the medicalization of a particular set of problematic behaviors. Additionally and importantly, there are forms of suffering that are deserving of medical attention but for which medicine still lacks the resources to fully relieve. In these cases, we consider the potential for medicine to relieve these forms of suffering as justifying them as medical problems. Thus, the healing capacity of medicine can be imagined in potential treatments yet to be developed or discovered. Recognition of this prospective capacity to relieve suffering is based on the fact that medicine is both a

healing art and a scientific enterprise and we have the experimental methods of science to ground hypothetical inquiries into medical advances. We see the scientific enterprise at work in the search for cures to cancer, vaccines to prevent HIV/AIDS, and research into autism. It is thus the healing capacity of scientific medicine—in the present or future—that helps us to recognize the specific forms of suffering that are medically remediable and forms that are outside the current or future domain of medicine.

The position of personality disorders along this continuum of suffering—ranging from the nonmedical (leaky roof) to the obviously medical (cancer)—can therefore arguably be tied to an assessment of whether medicine has or will have the tools to relieve that suffering. Some might argue that because the answer to this question is historically and culturally relative it renders whatever problems medicine attends to as being purely relativistic artifacts of time and place. I would not take issue with this objection. The focus of medicine depends on the state of medical technology, pharmacology, psychotherapy, etc. and a society's ability (or willingness) to deploy those resources. As a pragmatic theory, the technological and scientific sophistication of a society is simply a reality that must be taken into account. However, as I will describe below, several ethical caveats will be offered to provide guidance about how and why medicine *should* address particular forms of suffering if resources are indeed available. These more normative questions will require case-based analysis and ethical argument. For now, I propose a more straightforward account of why and how we might determine which forms of suffering matter for building the comprehensive pragmatic theory. The key will be to first identify those forms of suffering, for which medicine is equipped to

relieve. Thus, I am targeting 'behavioral constellations' that cause a particular species of suffering—one that intersects with the traditional ends of medicine.

What are these traditional ends of medicine? Here we circle back to a naturalistic account of disease and function, and look to Pellegrino for a useful definition: "Within the traditional ends of medicine, the primary intention is the use of biotechnology to treat physical or mental disease... The patient feels 'better' and regains functional capacity. He may be returned to his previous state of health, or to an even better state."[7] Pellegrino defines the 'ends' of medicine in essentialist terms in contrast to the 'goals' of medicine, which he believes are socially constructed and instrumental. He believes that the ends of medicine are intrinsic and universal to the healing profession and are actuated by individual physicians who abide by agreed-upon practices to achieve those ends. Thus, "physicians do not determine the ends of medicine; it is their task to realize these ends in a specific clinical encounter with a particular patient. Physicians are charged with ascertaining, together with the patient, the content of the end of healing."[8]

Pellegrino argues that the ends of medicine must never be subsumed by the goals or purposes of medical practice. Thus, the universal quality of the ethical healing relationship, about which he has extensively written, should determine the means of medical intervention and not vice versa. Pellegrino is wary of medical goals undermining the integrity of medicine by usurping the internal ends for pragmatic purposes. He cites the well-known cases of Nazi and Soviet medicine as historical examples of the ends-goals inversion. He reminds us, "whenever medicine is used for any purpose or goal—however defined—that distorts, frustrates, or impairs its capacity to achieve its proper ends, it loses its integrity as a craft and its moral status as a human activity."[9]

Make no mistake; Pellegrino's theory of the ends of medicine is anything but pragmatic. It is essentialist to its core, so it might seem strange I wish to call on it to build a comprehensive pragmatic theory. However, Pellegrino's argument is helpful for two reasons. First, as will become clearer, it reminds us to be cautious of creating a pragmatic theory of mental illness that overreaches. Pellegrino's cautiousness and conservatism on defining the true ends of medicine will be helpful in thinking through the moral boundaries that will be needed for an ethically justifiable pragmatic theory. Second, in defining the constellations of behavior that concern us for our theory, we should orient ourselves toward an 'end'. In contrast to Pellegrino's theory, our concept of 'end' is not an intrinsic *telos* that is somehow metaphysically embedded in the practice of medicine. For our account, this end is simply the pragmatic goal to ameliorate and prevent a particular species of human suffering. Therefore, the concept of the ends of medicine I am endorsing looks superficially much like Pellegrino's. Substantively, however, it is diametrically opposed. The concept of the ends of medicine I endorse is simply a heuristic device to help anchor the theory's other foundational concepts. It is a completely instrumental concept in that the 'ends of medicine' only exist insofar as they prove useful to us. This shift also entails instrumental goals of medicine might at times supersede our pragmatically defined end.

At first blush, another key difference between my account and Pellegrino's would seem to be that his theory is based on the central argument that the suffering to which medicine should exclusively attend is that of individual patients. For Pellegrino the end of medicine is for physicians to relieve the suffering of their patients; the benefits of medical intervention for others are considered secondary and should never constitute the

primary motivation for that intervention. However, it would seem Pellegrino would grant exceptions for involuntarily treating severely mentally ill individuals who pose a physical threat to other people. In these cases, the ideal end of medicine cannot be easily (or safely) achieved. In fact, the threatening individual might not be suffering at all, and, moreover, any medical intervention would actually cause them to suffer. In these cases, for the public's good, the instrumental use of medicine must guide our actions and the patient must be treated for the primary goal of ensuring public safety. It is at this juncture that I believe our accounts parallel. As I shall argue and illustrate through case studies, particular personality disorders present a unique risk to the public health such that we can and should consider the welfare of others in our process of categorizing these behaviors as medical problems. Granted, for personality disorders, involuntary treatment is generally not justifiable particularly because the threat they pose to others is not as grave as cases of extreme psychopathy. However, at the same time, the public health perspective can justify the provision of medical resources to those who are adversely affected by people with personality disorders.

Before considering the public health dimensions of the pragmatic theory of mental disorder, let us return to nosological issues related to diagnosing individuals. By understanding the end of medicine as aiming to relieve a specific kind of mental and physical suffering, we can then begin to parcel out behavioral constellations that deserve medical attention. At this point, our theoretical account of "behavioral constellations" does not yet provide a complete picture with enough theoretical relief to recognize questionable behaviors from the background of quotidian activities of life. To achieve this, it seems we need a more discrete behavioral unit to serve as our referent, so that

when examining instances of suffering, some of those units might rise above the noise of everyday activities to become behavioral constellations of concern. We need something to point to in order to build our pragmatic nosology. That something will be habit.

Habit

The needed resources to more clearly define the concept of 'behavioral constellation' can be found within William James's and John Dewey's expansive corpus on social psychology. Three sources will prove especially useful for this task— Dewey's early papers on the philosophic dimensions of psychology, James's *Psychology*, and Dewey's *Human Nature and Conduct.* Across both Dewey's and James's functionalist psychology are common pragmatic threads supporting empiricism and naturalism, a rejection of mind/body dualism, and the belief that all human behavior is marked by the interaction between the individual and both their natural and social environments. These theoretical fibers, when woven together, provide the starting point for identifying behaviors of concern as being empirical realities that individuals outwardly and habitually exhibit. Thus, 'behavioral constellations of concern' should be recognizable patterns and be scientifically verifiable, measurable, and predictable in much the same way as physiologic responses. This analogy will also be crucial for attaching my pragmatic theory to Boorse's naturalism at the juncture between the concepts of biological and social dysfunction.

In fact, Dewey's influential paper "The Reflex Arc Concept in Psychology" extends the analogy between mental states and functions and autonomic physiological functions. In that paper Dewey argues that the physiologic concept of the reflex arc was

misunderstood and this resulted in a similar misunderstanding of psychological functions. For Dewey, the stimulus and response is a single circular unit and not a disjointed arc, as had been earlier described by structuralists who viewed the stimulus-response (or stimulus-mental state) dyad as a linear cause and effect. In contrast, Dewey's was a functional account, which explained behavior according to the contemporaneous coordination between phases of stimulation and response; an insight that provided the intellectual basis for development in social psychology.

Understanding responses as continuous with stimuli will help to clarify—but also complicate—the determination of units of behaviors. For example, when we consider the borderline personality disorder, we will see that the behaviors often associated with the disorder, such as impulsivity and manipulation, cannot be easily disentangled from the social structures that might have partially caused or continue to reinforce those behaviors. In other words, the behaviors we are concerned with are not simply reflexive reactions to stimuli. Dewey's notion of the interdependence of the stimulus-response allows us to begin to think about various behaviors—albeit reflexive ones—as part of a larger psychological and social context. Contextual analysis of particular behaviors is critical to understanding the etiology and current classification of personality disorders, since as we now know, the DSM defines personality disorders in terms of cultural expectations. Yet, for all of its influence in social psychology, Dewey's theory of the reflex arc in psychology remains too basic. It only provides a way to think about simpler instances of the stimulus-response complex. What is needed is a more robust account of personality, one that allows us to say: "This or that *set* or *pervasive pattern* of behaviors seems dysfunctional."

To build the needed pragmatic ontology of behavioral constellations we should now shift over to William James's *Principles of Psychology*, published more-or-less contemporaneously with Dewey's "Reflex Arc".[10] Here we find James's theory of habits, which is a naturalized account of both basic and complex patterns of human behavior. For James, habits have "a physical basis" that can be identified through the basic laws of physics governing the way structures (built up from elementary particles) react to "outward forces and inward tensions."[11] It is the plastic capacity of complex structures of matter to bend, to stretch, and to later recover that marks the physical basis for habits in humans. In living beings, "the phenomena of habits...are due to the plasticity of the organic materials of which their bodies are composed."[12] It is this plasticity that allows the mind to be reshaped according to a person's repeated ways of life. Accordingly, for James, habits become psychologically and physically imprinted. They are the tracings found in the brain caused by particular nerve impulses repeatedly pulsing across and through the same nervous centers. Like a river cutting its way through a canyon, the neural imprints of habits deepen each time they are performed.

James believes that our propensity to form and perform habits can be most advantageous. Habits save us the time and energy it would otherwise take to think through each of our daily activities. Habits provide stability to the individual as they age and mature. Habits are the "enormous fly-wheel of society"—they conserve the *status quo* of social institutions and strata, arguably allowing society to function without constant upheaval. At the individual level, the formation of healthy habits is necessary for both basic psychological health and for achieving higher levels of productivity. We must "make automatic and habitual, as early as possible, as many useful actions as we

can, and guard against the[m] growing into ways that are likely to be disadvantageous to us, as we should guard against the plague. The more of the details of our daily life we can hand over to the effortless custody of automatism, the more our higher powers of mind will be set free for their own proper work."[13]

From his thinking on the circuitous nature of stimulus and response, and building off of James's work, Dewey eventually developed his own theory of habits, which he claimed were characterized as,

> an acquired predisposition to *ways* or modes of response, not to particular acts except as, under special circumstances, these express a way of behaving. Habit means special sensitiveness or accessibility to certain classes of stimuli, standing predilections and aversion, rather than bare recurrence of specific acts. It means will.[14]

For Dewey, it is the concatenation of habits that defines individual character, and we can make sense of personal choices only by understanding habits. This is to say individual habits drive choices in that they set up the range of foreseeable options based on habituated "predilections and aversions." However, these habits are not discrete but are rather interdependent and are in fact impossible to disentangle from one another:

> All habits are demands for certain kinds of activity; and they constitute the self. In any intelligible sense of the word will, they *are* will. They form our effective desires and they furnish us with our working capacities. They rule our thoughts, determining which shall appear and be strong and which shall pass from light into obscurity...We may think of habits as means, waiting, like tools in box, to be used by conscious resolve. But they are

> something more than that. They are active means, means that project themselves, energetic and dominating ways of acting.[15]

As Allport notes, as Dewey's concept of habits evolved over the decades it became somewhat riddled with equivocation.[16] Nonetheless, the basic concept as described in *Human Nature and Conduct* reflects one aspect of what I mean by a "constellation of behaviors" that will be subjected to our pragmatic analysis. Indeed, within Dewey's social psychology, habits occupy a central role: they are a mark of function and dysfunction. Good habits are akin to physiological functions in the way they provide for the flourishing of the individual. In a broader sense, habits also constitute the individual threads that make up the fabric of human community: "Our individual habits are links in forming the endless chain of humanity."[17] The implication of this understanding of habit—that they form the basis for community relations—is important because it supports the commonsense claim that an individual's good or bad habits affect other people. And so, we can begin to address the form of suffering that is caused by dysfunctional habits while also recognizing the transmissible quality of this suffering. The particular individual with the personality disorder is the primary node of this suffering, which is transmitted, somewhat virally, to their relations.

By combining James's theory of habits, with Dewey's basic reflex arc concept and his more robust theory of habits, a clearer picture of what is meant by 'constellations of behaviors' now emerges. By defining constellations of behavior in terms of habits, we not only can identify specific patterns of behavior as separable from other activities of daily life, but also, begin to assess the dysfunctional dimensions of those behaviors. We can now also argue that personality disorders are characterized by sets of dysfunctional

habits. For example, when we look at borderline personality disorder, these habits will include a propensity to react with intense anger, paranoid ideation, suicidal gestures or threats, self-mutilating behavior, and frantic efforts to avoid abandonment.

From a pragmatic perspective, then, these dysfunctional habits include a wide array of behaviors that continuously stifle and erode the disordered person's interpersonal relationships. They likely push the disordered person into social isolation making it difficult or impossible to for that person to flourish, and causing the pathological feedback loop of alienation. The habitual nature of these behaviors makes them extraordinarily difficult to change because they are embedded in the psyche of the disordered individual. And it is both the pervasiveness and incorrigibility of destructive habits that mark out the constellations of behaviors that are characteristic of personality disorders. Such habits become inevitable, as they impede one's will to think or act otherwise. Habits typically associated with personality disorders will persist even after repeated instances of negative feedback, therapeutic interventions, or other attempts to retrain the patient.

How is it that such habits, which seem to be incompatible with human flourishing, form and persist? Research into etiology of the dysfunctional habits associated with borderline personality disorder provides evidence that they are formed in response to severe childhood abuse, trauma, or abandonment. Though it is still unclear whether the association between abuse and BPD is correlation or causal, the evidence is quite compelling that both genetics and childhood abuse combine to cause "emotional dysregulation and impulsivity" that are the bases of the more specific dysfunctional behaviors, which, in turn, amplify additional social causes.[18] They are primitive coping

mechanisms that are solidified in the nascent character of young persons. As such, dysfunctional habits are more deeply embedded in the minds of the disordered adult. Resonating James's theory of habit, people who have personality disorders can be described as lacking a normal degree of resilience when faced with stressors. It is this rigidity that makes them resistant to rehabituating in more functional ways. Moreover, the dysfunctional habits of people with personality disorders are often described as being incorrigible. The neural tracks of the dysfunctional habits are burned into the psyche so deeply they cannot be rerouted.

At this point, the concept of habit grades into our next set of questions. These concern making normative judgments about the specific habits or behaviors in question. Although I have just described some habits that can be considered to be functional or dysfunctional depending on their pragmatic capacity to make one's life more efficient or easier, we still need to subject this distinction to further analysis so that we do not base our nosology on behaviors that are better described as moral failings or vices.

Beyond "Bad or Mad?"

It might seem that a comprehensive pragmatic theory of mental illness that aims particularly for understanding and better addressing the question of personality disorders must first set out a set of criteria to determine whether behaviors in question are instances of moral vice or potential medical problems (or both). Arguably, what is of central importance to the nosological pragmatist is first to begin drawing lines between instances of bad behavior and behavioral constellations that seem to be outside the control of the individual. It seems obvious that we would not want to include instances of vice in our

nosology, but similarly we would not want to mistake potential mental disorders as being simply vices. This question is sometime simplified in the philosophy of psychiatry literature in terms of distinguishing the 'bad' from the 'mad' and volumes of philosophical and historical research have been devoted to drawing this distinction more clearly.

Indeed, for millennia moral philosophers have been puzzling over a way to clearly demarcate vicious behavior from other disordered behaviors. As is well known, Aristotelian virtue theory provides a model for understanding vicious behaviors as being either a deficiency or excess of a particular property, the mean of which would be a virtue. Virtuous and vicious persons, in turn, can be distinguished from those who are continent (*enkrateia*) or incontinent (*akratês*); in each respective case, these people might happen to act virtuously, without necessarily desiring to do so, or lack the willpower to resist the inclinations of their appetites. In this context, the crux of the 'mad' or 'bad' question is located in our understanding of the role of the will to account for the actions of the individual. For example, the impetuous akratic person acts on their passions (*pathos*) without reasoned deliberation while the weak akratic person acts in spite of and in conflict with their reason deliberation. Both forms of incontinence mark a form of uncontrolled or impulsive behavior that is less blameworthy than vicious actions.

In a similar way, in his *Anthropology*, Kant distinguishes between persons who lack the ideal collection of moral and intellectual virtues from those whose reason and understanding are well tuned toward acting morally. Kant argues those who are diminished in their ability to deploy the higher faculties of cognition (Understanding) suffer a sickness of soul. As Kant tells us, the overarching power of Understanding

consists of more specific elements of understanding, such as the power of judgment (*iudicium*) and reason. He claims that the healthy mind is composed of "correct understanding, practiced judgment, and thorough reason."[19] Of course, this idea dovetails with Kant's moral philosophy, within which heteronomous actions are contrasted with freely chosen autonomous action. One source of heteronomy would be Kant's concept of sickness of soul, which inhibits a person's ability to separate impulse from reasoned action. For our purposes, we might conclude that the inability to differentiate between primitive sensual impulses and well-formed thoughts derived from human understanding and reason may serve as the demarcation for Kant's notions of mental illness versus vice.

As I mentioned in earlier, Foucault reexamined Kant's *Anthropology* in his early writings (including for his own dissertation on Kant's psychology) and laid the foundation for his well known, albeit controversial, historical-philosophical account of how the 'mad or bad' question has been addressed in Western society since the Middle Ages. The origins of the distinction, Foucault claims, can be first located in the era between the Middle Ages and the Enlightenment, when the mad were cast out of their community and shipped from port to port on the Ship of Fools (*Stultifera Navis*) in search of a sympathetic host community.[20] The mad were marked as outsiders who were exiled, much like lepers, from the city centers. Through the 17th-19th century, during what Foucault calls "The Great Confinement," mentally ill people were confined with criminals, vagrants, tramps, and other social undesirables. By the 1800's, the mentally ill were housed separately from criminals, in particular because, as William Tucker argues, "observers who distinguished 'mad' from 'bad' had decried the fact that criminals were forced to endure the screams of the insane, which added to their punishment."[21]

Tucker also notes that this concern was reversed by the late 1800's by metal health advocates and researchers such as Philip Pinel, the Tukes, and Dorthea Dix all of whom championed providing treatment, not criminalizing, the mentally ill.

What these historical thumbnails suggest is that the answer to the vexing question of how to cordon off vice from mental illness has most commonly turned on a theory of free will and its allied concepts: autonomy, freedom and personal responsibility. And so it would be unrealistic to expect a pragmatic theory of mental illness to offer a robust solution to this debate along these traditional lines. In fact, the inability to attend to and resolve this theoretical question conclusively is a limitation that is recognized and actually built into our pragmatic theory. But what the pragmatic theory should do, in the very least, is provide a satisfactory method to begin our analysis of constellations of behavior that we might wish to consider as mental disorders. To do this, a pragmatic reframing of the question about vice and disorder is required.

We should first recognize that the question of 'mad or bad' creates a false dichotomy that requires further (and unnecessary) theorizing. Indeed this question pushes the answerer to reify behaviors according to a set of pretheoretical criteria, which directly relate to a question about whether the action or behavior was freely chosen or whether the behavior is somehow unintended and ill-controlled. Thus, the typical response to the question of whether a person is mentally ill or simply vicious turns on the extent to which that person should be held responsible for their actions. The ascription of mental illness should exculpate such a person, while the identification of a behavior as a vice or as immoral should render them blameworthy. [22]

The pragmatist would first respond that the question of whether a person is mad or bad as it has been traditionally framed begs the central question that that person has free will to begin with. Moreover, as James would claim, the question of free will is irrelevant for the purposes of our inquiry and that the concept of free will itself is simply a nominal construct, which is helpful in motivating progressive efforts (meliorism) but theoretically undecideable.[23] To wit, with regard to the sorting out of free will and blameworthiness, James argued in his lecture "Some Metaphysical Problems" from *Pragmatism*:

> Instinct and utility between them can safely be trusted to carry on the social business of punishment and praise. If a man does good acts we shall praise him, if he does bad acts we shall punish him—anyhow, and quite apart from theories as to whether the acts result from what was previous in him or are novelties in a strict sense. To make our human ethics revolve about the question of 'merit' is a piteous unreality—God alone can know our merits, if we have any. The real ground for supposing free-will is indeed pragmatic, but it has nothing to do with this contemptible right to punish which has made such a noise in past discussions of the subject. [24]

For James, free will, as such, is nothing more than a "general cosmological theory of Promise, just like the Absolute, God, Spirit, or Design."[25] As a pragmatic concept however, free will is necessary for James's larger melioristic vision because it allows us to hope and strive for social progress. Furthermore, the concept of free will is not meant to be used for putative purposes. For the pragmatist, the seductive impulses to blame and

hold accountable, when based on a notion of free will, are really spiteful vestiges of human history. Again, James:

> You know how large a part questions of *accountability* have played in the ethical controversy. To hear some persons, one would suppose that all the ethics aims at is a code of merits and demerits. Thus does the old legal and theological leaven, the interest in crime and sin and punishment abide with us. 'Who's to blame? whom can we punish? whom will God punish?—these preoccupations hang like a bad dream over man's religious history.[26]

The key question that must be answered is not whether a person is blameworthy for their behavior but whether ascribing a label to them related to their mental functioning is helpful to that person, their family, and the larger community. Therefore, we must move beyond the impulse to either assign blame or exculpate individuals for their actions and consider, instead, how best to efficiently manage such behavior if it is deemed problematic.

Let us consider a simple example to illustrate this central point: A person who is addicted to heroin is arrested for the petty theft they committed to support their drug habit. Some will argue that that person has committed a crime and thus should be punished. They will claim that retributive justice requires that the thief make amends for their crime by providing recompense to the victim or serving time in prison. Others will claim that the person suffers from a form of mental illness—an opiate addiction which is both physiologically and psychologically based—and thus should be provided the resources to be treated for their addiction. They will probably marshal empirical evidence

about the effects of heroin addiction on the brain and show how it leads to behaviors that are largely uncontrollable. A third, more likely, response might combine the two and argue that the addict should be held accountable for their actions in some way, but is nonetheless not completely blameworthy for their actions. They might propose sanctions such as compulsory treatment with the threat of imprisonment.

Underlying each of these positions is an assumption about the addict's degree of responsibility and a demand for accountability for her actions. The first reply is characteristic of a moralist who judges the addict's behavior—both in abusing heroin and in committing petty crimes—as being a simply the result of a poor choice by the criminal that was made voluntarily. The second reply might be characteristic of an addiction-as-disease apologist who seeks to exculpate the addict for their poor decisions on the basis that they are not in control of their actions, and thus should not be held responsible for behaviors that are not volitional. The third seeks to blend these two. Notwithstanding glaring exceptions, the third response is representative of what often takes place in our current criminal justice system in dealing cases addiction and petty crime.

A pragmatic response to this case would be fundamentally different than the three I just sketched. The answer to the theoretical question regarding the blameworthiness or volition of the heroin addict is largely irrelevant. Instead, the pragmatist will want to first know what kind of outcomes the available options offer, and whether those outcomes will be beneficial to the addict and the community at large. It might be the case that it would be best to imprison the addict for a time—not for retributive purposes but rather to both wash out the drug and provide a behavioral deterrent for theft—and then set them on a structured path toward addiction recovery. Or it might make better sense to forget about

incarceration and simply provide this addict with controlled doses of methadone, buprenorphine or heroin to eliminate future risk of petty theft. The goal here is not to appeal to sacrosanct principles of retributive justice, but rather to figure out what strategy is most efficient and practically doable and which will maximize the most good for all the stakeholders.

Nonetheless, especially for cases of Cluster B personality disorders, clinicians and researchers remain concerned with the role of personal responsibility and frame the question in terms of the dilemma between freedom and illness. Siever and Koenigsberg, for example, commenting on the promise of neuroscience research on borderline, present the dilemma thusly:

> At a time when psychiatry is grounding one severe mental disorder after another in brain biology, borderline personality disorder confronts us with an enigma—and a clinical dilemma. We have little trouble understanding how a man with a tumor impinging on his frontal lobes may become irascible and display poor judgment, or how someone with an abnormal organization of her brain may hear voices and act out of touch with reality. But we resist seeing the moody, irritable, apparently manipulative and willful behavior of "borderlines" in terms of the biology of the brain; it seems to absolve them of responsibility for their aggressive, antisocial, or even outright criminal acts. [27]

In other words, according to this framing of the issue, a clinician who is treating a borderline can embrace the biological basis of the disease, but only at a cost: that of exculpating to some degree the patient from responsibility for her behavior. Conversely,

a skeptic who doubts the evidence about the role of neurological dysfunction in personality disorders will push from the other side of the apparent dichotomy. They might argue, for example, that correlational data about the size of the amygdala should not excuse people from acting out in ways that are socially disruptive. When framed in this way, arguments about the nosological validity and signs and symptoms of personality disorders grade into questions about accountably, freedom, and personal morality.

The pragmatist wants to reject the dilemma altogether and thus avoid confounding it with moral or ethical judgments. For the pragmatist, the question related to whether a constellation of behaviors is a vice or a mental disorder is largely irrelevant, except in the way that determination might lead to particular consequences. This is to say, the determination of whether to consider a constellation of behaviors is a mental illness should not rely on a theory of responsibility. Rather, such a determination should first examine the nature and locus of the suffering and decide whether psychiatry has or might have the resources to relieve that particular form of suffering. Second, the pragmatic examiner must assess whether the ascription of 'mental disorder' will offer more positive results than ill effects. If the answer to these questions is a tentative 'yes' then that constellation of behaviors might be a candidate for the label 'mental disorder'. In the end, the pragmatic response to the 'mad or bad' dilemma happens through a transformation of the question itself into one in which an answer is actually possible, one which yields a way forward leveraging available empirical evidence toward reaching the goals of a fully functioning and ever-progressing community.

As I will discuss, transcending the mad or bad distinction can cut both ways. We can make pragmatic claims about how to best manage behaviors and reject the

dichotomy—as I propose—or we can embrace both choices in the dichotomy by both ascribing the label of mental disorder *and* blaming sufferers for their behavior. In other words, we can find many examples of the tendency to accuse people with personality disorders of a 'willful madness' that is the cause of their troubling behavior. Particularly with borderline personality disorder, the ascription of mental disorder has done nothing to preclude clinicians and nosologists from casting implicit or explicit blame on borderline patients for their illness.

Nancy Potter cites several instances of this in textbooks, including in Millon's in which he tacitly lays blame on deliberate actions of patients. She says his use of scare quotes indicates this much. I agree—and would assert this description delegitimizes the patient's own account of her suffering. "Depression serves as an instrument for them to frustrate and retaliate against those who have 'failed' them or 'demanded too much.' Angered by the 'inconsiderateness' of others, these borderlines employ their somber and melancholy sadness as a vehicle to 'get back' at them or 'teach them a lesson'."[28] Millon continues on from there in a similar way. What we will see in the next chapter is such inferences that blame sufferers of a personality disorder are antithetical to the ethical-pragmatic goal of ascribing mental disorders for the good of the patient. This insight I believe will further support my argument the pragmatic ascriptions of mental disorder must resist the temptation to engage the standard debate about blame and illness, and instead embrace outcomes based management strategies.

Hypersexuality & the Consequences of Exculpation

The pragmatic approach to dealing with personality disorders would seek to avoid the ethically fraught questions related to personal responsibility as constitutive of mental disorder or not. That said, however, the *consequences* that result from a perception of exculpation should be explored. As I mentioned, in addition to maximizing the benefits of all involved, the pragmatic theory must also account for the potential harms associated with relieving individuals of personal responsibility through the ascription of mental illness. In other words, for the pragmatic theory to be coherent, it must be selective and equipped to reject particular forms of behavior that are not best treated as medical disorders, leaving them to other social institutions for appropriate management.

The recent rash of so-called sex addiction cases illustrates the difficult problem of negotiating a proper balance when distinguishing between medical problems and social or individual problems. Although sex addiction is not the DSM-IV, a broader category, hypersexual disorder, is being considered for DSM-V. One proposed definition is the following:

> Over a period of at least six months, recurrent and intense sexual fantasies, sexual urges, and sexual behavior in association with four or more of the following five criteria: (1) A great deal of time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behavior. (2) Repetitively engaging in these sexual fantasies, urges, and behavior in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability). (3) Repetitively engaging in sexual fantasies, urges, and behavior in response to stressful life events. (4) Repetitive but

unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behavior. (5) Repetitively engaging in sexual behavior while disregarding the risk for physical or emotional harm to self or others.

The proposal stipulates that these criteria can be further specified by the way in which they manifest. Examples offered include excessive masturbation, viewing of internet pornography and repeatedly visiting strip clubs. Note that a consideration of the welfare of other individuals is explicitly built into the defining symptoms of hypersexuality. Additionally, part of the work group's rationale for including hypersexual disorder is popular demand: "There is a significant clinical need, even a 'demand' from mental health consumers, for mental health providers to recognize and diagnose a distinct group of men and women who have been seeking and are already receiving mental health care such as individual psychotherapy, 12-step group support, pharmacotherapy, and specialized residential treatments." Indeed, as of late, famous movie stars, politicians, and athletes, have committed themselves to rehabilitation regimes to correct or ameliorate the "disorder" that ostensibly caused them to repeatedly commit adultery, call on prostitutes, etc.

Proponents of its medicalization will point to reports that hypersexual behavior has been observed as a sequalae to various neurological disorders or injuries. For example, there have been reports of hypersexual behavior resulting from strokes, which were marked by an increase in libido, priapism (prolonged erection), and sexually deviant behavior. [29] Another study has pointed to hypersexuality as a result of iatrogenic brain lesions caused when placing intracranial shunts.[30] Additional investigations on multiple

sclerosis, Parkinson's disease, epilepsy and other brain-based disorders such as Klüver-Bucy syndrome and dementia have uncovered instances of acquired hypersexuality marked with paraphilia.[31] In most of these cases hypersexual symptoms have been correlated with temporal lobe disturbances or damage.

It is less clear that cases of idiopathic hypersexuality to be classified in the DSM-V would be the result of a discrete neurological injury. To the contrary, psychiatrists have proposed a categorically different kind of hypersexuality that is not defined in terms of biological injury or dysfunction. Rather its definition is explicitly normative and based on a descriptive phenomenology of the behavior. For example, Stein, et al. argue that hypersexuality is culture-dependent:

> ...the judgment that the sexual fantasies, urges, or behaviors are excessive (i.e., represent psychopathology) must take into account normal variation as a function of age (e.g., in teenagers, high levels of preoccupation with sexual fantasy may be normative) and subcultural values (e.g., in patients who value celibacy, the presence of some sexual urges and associated distress may be normative), as well as the degree to which the symptoms are the source of distress or interfere with important areas of functioning... the problem of delineating normal variation from psychopathology is particularly difficult when, as in the case of hypersexual disorder, the form of the phenomenology is (by definition) normative. [32]

The point here is not necessarily to be skeptical about hypersexual disorder as a psychiatric category because of the nature of particular behaviors or the role of the free

will in choosing to engage in those behaviors, but, rather, to first question whether medicalizing them will have a broader positive outcome and to consider within that calculation empirical evidence about the ways our understandings and expectations about personal responsibility might be reshaped. As part of this tally, we might consider slippery slope type ramifications for the expansion of mental disorder to include hypersexuality: will the creation of an official category for hypersexuality lead to the medicalization of other forms of sexual behaviors or habits? Will it reintroduce problematic categories such as masturbation into the nosology, for example?

More substantively, we might consider the effects of an official appellation by asking whether a diagnosis of hypersexuality will in fact reduce the risk and actual harm caused by the individual against themselves, their spouses or lovers. Perhaps formalizing the category of hypersexuality will open up promising avenues for treatment. Some might argue that the ascription of mental disorder to habits associated hypersexuality will be in fact helpful, because it will provide a more formal research structure from which we might understand other forms of impulsivity and reckless behavior. Indeed, the DSM-V work group cites this possibility as a rationale in its proposal.[33] One final, albeit not minor consideration, that is implicit in the reference to the demands of mental health consumers and practitioners is that once hypersexuality is an official disorder, its treatment can be paid for by insurance.

Additionally, anthropologists and sociologists have tracked the way in which blame and mental illness are often mutually exclusive. Admonishment, blame and, to a certain extent, stigma are significantly diminished by finding a biological basis (or mere correlate) for a particularly problematic behavior. As T.M. Luhrmann offers, "Biology is

the great moral loophole of our age...a moral vision that treats the body as choiceless and nonresponsible and the mind as choice-making and responsible has significant consequences for a view of mental illness precariously perched between the two."[34] To wit, the 100,000 member strong National Alliance for the Mentally Ill (NAMI) explicitly contends that mental illnesses are completely somatically based and they espouse a 'no-fault' policy, exculpating both patients and, in the case of mentally ill children, their parents. [35] (This fact will become important in the following chapter as we explore the way particularly powerful stakeholders influence psychiatric diagnoses.)

We should note that NAMI's push to frame mental illness in terms of the biomedical model of disease aims in part to minimize stigma suffered by the mentally ill. But, as it turns out, research suggests that a biologically based concept of mental illness might not reduce the amount of stigma at all.[36] In fact, and somewhat surprisingly, the "brain disease" narrative might have the opposite effect and actually increase stigma because diseased individuals are considered to exist within a separate social category altogether. In contrast those who are simply behaving badly continue to reside in the mainstream and thus receive tacit acceptance despite the disruptions they might cause. The point is that we must have an accurate accounting of costs and benefits before haphazardly applying the biomedical model of disease to boundary cases simply because our intuition tells us such an ascription will serve the best interests of people who are suffering in some way that seems amenable to medical intervention.

To summarize, my goal here is not to render a clear verdict on the case of hypersexuality, or other cases of potential pseudoillnesses, in relation to the question of free will. Rather, my aim is to simply remind the reader that questions pertaining to vice

and disorder should not be conflated with pragmatic assessments of how best to manage problem behaviors. We see in the case of hypersexuality an illustration of the potential risks and benefits of blaming as vicious or, alternatively, exculpating as disordered those who engage in a particular set of sexual behaviors. Yet, from a pragmatic perspective, the first question that needs to be answered is whether and how medical resources can or should be brought to bear to minimize the suffering caused by the sexual behavior of "addicts." If medical resources offer little or no benefit to sex addicts or to the community then another social institution should address the behaviors associated with sex addiction, if they are to be addressed at all.

Public Health & Personality Disorders

Part of my pragmatic theory will be to justify the inclusion of the behaviors of concern as disorders within the psychiatric nosology on the grounds that they present a public health risk. The ascription of mental disorder is the key that unlocks another armamentarium of resources in public health, which can help minimize the suffering caused by personality disorders. As Coid has argued, addressing the problem of personality disorders through the public health model requires an approach that is rarely if ever applied to them.[37] The public health problem-solving paradigm, as described by Guyer, includes the following steps: (1) define the problem (2) measure the magnitude of the problem (3) develop a conceptual framework for key determinants of the problem, including biological, epidemiological, sociocultural, economic and political determinants; (4) identify and develop interventions and prevention strategies; (5) set priorities among strategies and recommend policies; (6) implement programs and evaluate them. This

framework will be helpful when we begin to think about policy ramifications of our pragmatic theory of personality disorder. [38] Suffice it to say, each of these steps requires additional research into the biological and sociocultural forces that combine to cause and exacerbate personality disorders.

Nonetheless, there are presently enough data to make some general claims about personality disorders as public health concerns; although compared with depression or schizophrenia, there are not many epidemiological studies on personality disorders. Yet in specific case of personality disorder, such as borderline, there are compelling data that suggesting these disorders are both prevalent and costly. Moreover, public health researchers are beginning to paint a picture of the increasing prevalence of personality disorders (and their comorbidities such as depression) in the community. For example, in 1991, it was estimated, that the prevalence of borderline was as high as 1.8% of the general population. [39] More recent data indicate that the prevalence of borderline to be above six percent, though it should be acknowledged that these increases might in part be an artifact of diagnostic drift.[40] A 2006 study in the UK showed that the prevalence of personality disorders, in general, to be 4.4% with Cluster B disorders as being especially costly.[41] In a recent metaanalysis, Eaton, et al. provide further evidence of their prevalence. They indicate the prevalence of personality disorders to be nine percent, and the enormous annual cost of treating personality disorders is estimated to be the hundreds of billions of dollars. The indirect savings however in treating or preventing personality disorder is difficult if not impossible to quantify at this point because of the dearth of data. I will expand on these considerations in chapter 8 when I offer health policy recommendations based on the pragmatic theory. The point here is that we can establish

empirically that the constellations of behavior we are considering as disorders are prevalent and costly.

A second question we might ask from a public health perspective is, "Are personality disorders 'contagious' and do they pose a risk to the health of others in the community?" If they do, this fact will amplify the costs of personality disorders and provide additional justification for prevention and treatment of the disorders as well as taking measures for the benefit of others who are at risk. As I suggested in the previous section on the ends of medicine, personality disorders could be understood in terms of their effects on others. As such, we can partially justify medical interventions for both preventing and treating personality disorders not simply to treat the patient but to protect the larger community from the effects of such disorders. Additionally, we can justify the allocation of medical resources to those who are directly affected by personality disorders.

Although difficult to prove causation definitively—again because of a lack of data—it is reasonable to argue from what we do know that personality disorders contribute to depression, anxiety, and other common but debilitating mental illnesses in the community, which are themselves "contagious" to a certain degree.[42] Moreover, there is a strong correlation between emotional or physical abuse of intimate partners, spouses or children and personality disorders.[43] For those in relationships with people with personality disorders, we see an increased likelihood of depression, anxiety and other mental illnesses.

To further illustrate how public health perspective supports a pragmatic theory of mental disorder, consider analogous cases in which public health measures have had a

profound impact on improving health outcomes. For example, I cite efforts to maintain safe drinking water, eliminating toxins from food, public health campaigns to decrease the prevalence of tobacco use, or vaccination efforts. In each case, social and medical resources are deployed in a large-scale fashion to both prevent and minimize the effects of the target problem.

One key difference is that in the standard cases of public health intervention that I mention, the target is an entity that exists independently from the public risk it poses. Small pox is a disease caused by the variola virus, whether it affects one person or spreads to 1000 people. The fact that small pox is easily transmissible is not part of the explanation of its existence; rather it is a secondary characteristic of the disease. In the case of personality disorder, however, the ontological story is different. What I am arguing is that the risk posed to the public health is actually *one constitutive element* of the nosology that includes personality disorders. This is particularly the case with Cluster B disorders, which are marked by socially dysfunctional behaviors and which have a direct negative impact on others. Simply put, in the case of a pathogen we are talking about natural kinds. In the case of personality disorders we are talking about artificial or pragmatic kinds that are defined, in part, by their pernicious impact on others. So, admittedly, the comparison to viral contagions is logically problematic.

Notwithstanding this disanalogy, we can utilize the public health model to help address the costs and risks that personality disorders in fact do present to the broader community. Therefore, when we consider the evidence of the broad social and economic impact of mental illness, it seems reasonable to suggest that specific instances of mental illness such as personality disorders should be viewed in much the same way as other

public health problems. Again, this issue will be taken up in further detail in the chapter on policy. For now, it is important to understand that the potential of the public health model in mitigating the effects of personality disorders represents yet another facet in their being considered medical problems.

Conclusion

The goal of this chapter was to begin to describe what a pragmatic theory of mental disorder will look like. As I described, such a theory requires we situate its target—constellations of behavior of concern—within the broader context of medicine, as we also must adequately define them. To do this, I argued that a personality disorders seem to cause a form of suffering that intersects with the traditional ends of medicine. I also cross-analyzed these behaviors with the concept of habits from pragmatic philosophers to more clearly mark out the kinds of behavioral units to which the comprehensive theory should address. I also attempted to show how the pragmatic theory would address the common question of whether the habits or behaviors in question would more appropriately be considered instances not of mental disorder but of vice. Here we saw the pragmatic shift toward assessing the consequences and empirical realities of ascriptions of mental disorder as the key to deciding what is an otherwise irrelevant distinction. In the next chapter, I will continue to expand on my proposed comprehensive pragmatic theory by describing the key ethical subtheories, which I believe should be used to guide its application to particular disorders.

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1. American Psychiatric Association, "Definition of a Mental Disorder" http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=465 (accessed February 11, 2010).

2. "Laura" is from Paul T. Mason and Randi Kreger, *Stop Walking On Eggshells* 2nd ed. (Oakland, CA: New Harbinger Publications, 2010), 65, 97, 54, respectively; "Anthony" is from Anthony Walker, *The Courtship Dance of the Borderline* (San Jose, CA: Writer's Showcase, 2001); reprinted in Nancy Nyquist Potter, *Mapping the Edges and the In-Between*, (New York: Oxford University Press, 2009), 47.

3. Mary C. Zanarini, Frances R. Frankenburg, Christine J. DeLuca, John Hennen, Gagan S. Khera, and John G. Gunderson, "The Pain of Being Borderline: Dysphoric States Specific to Borderline Personality Disorder," *Harvard Review of Psychiatry* 6, no. 4 (1998): 201-207.

4. Arthur Kleinman and Joan Kleinman, "The Appeal of Experience; the Dismay of Images: Cultural Appropriations of Suffering in Our Times," in *Social Suffering*, ed. Arthur Kleinman, Veena Das, and Margaret M. Lock (Berkeley, CA: University of California Press, 1997), 2.

5. It should be noted that some mental health professionals view road rage as a sign of a deeper disorder (Intermittent Explosive Disorder) that is worthy of treatment.

6. Admittedly, this assertion is controversial. Some argue that SSRI's are nothing more than active placebos. See, for example, Irving Kirsch, *The Emporer's New Drugs: Exploding the Antidepressant Myth* (New York: Basic Books, 2010).

7. C. Ben Mitchell, Edmund D. Pellegrino, Jean Bethke Elshtain, John Frederic Kilner and Scott B. Rae, *Biotechnology and the Human Good.* (Washington, DC: Georgetown University Press, 2007, 121.

8. Edmund D. Pellegrino, "The Goals and Ends of Medicine: How Are They to be Defined?" in *Physician and Philosopher — The Philosophical Foundation of Medicine: Essays by Dr. Edmund Pellegrino*, ed. Roger J. Bulger and John P. McGovern, (Charlottesville, VA: Carden Jennings Publishing, 2001), 62.

9. Ibid., 63.

10. William James, *Principles of Psychology.* (New York: Henry Holt & Company, 1890).

11. William James, *Psychology: American Science Series, Briefer Course.* (New York: Henry Holt & Company, 1915), 134.

12. Ibid., 135.

13. Ibid., 144-145.

14. John Dewey, *Human Nature and Conduct: An Introduction to Social Psychology.* (New York: Henry Holt & Company, 1922), 42.

15. Ibid., 25.

16. Gordon Willard Allport, "Dewey's Individual and Social Psychology," in *The Philosophy of John Dewey,* Vol. 1, ed. John J. McDermott, (Chicago: University of Chicago Press, 1981), 272.

17. Ibid., 21.

18. Klaus Lieb, Mary C. Zanarini, Christian Schmahl, Marsha M. Linehan, and Martin Bohus, "Borderline Personality Disorder," *The Lancet.* 364, no. 9432 (2004): 453-461. As Lieb, et al. point out, "Data for the role of genetic factors are sparse. In one twin study, based on DSM-IV criteria, concordance rates were seen for borderline personality disorder of 35% and 7% inn monozygotic and dizygotic twin pairs, respectively, suggesting a strong genetic effect in the development of the disorder." (454)

19. Immanuel Kant, *Anthropology from a Pragmatic Point of View,* ed. Robert B. Louden (New York: Cambridge University Press, 2006), 7:198.

20. Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason.* (New York: Random House, Inc., 1965).

21. William Tucker, "The 'Mad' vs. the 'Bad' Revisited: Managing Predatory Behavior," *Psychiatric Quarterly* 70, no. 3 (1999): 221-230.

22. I should note that such pragmatic shift seems to have occurred in the framing of such concepts as psychopathy and sociopathy. These terms are found in the controversial definition of antisocial personality disorder through the DSM-II through DSM IV-TR. They are often associated with criminal behavior. Within these volumes the term psychopathy has been used as both a symptom of severe mental disorder and is now considered to be a validated metadisorder, which is characterized by an amalgam of symptoms of various personality disorders. Robert Hare's work in composing his multi-volume Hare Psychopathy Checklist has been used to assess and diagnose psychopathy and criminality. It also offers a predictor of recidivism. Recently, the Checklist has met with critique and controversy. See: Jennifer L. Skeem and David J. Cooke, "Is criminal behavior a central component of psychopathy? Conceptual directions for resolving the debate," *Psychological Assessment* 22, no. 2 (Jun. 2010): 446-54.

23. William James, "The Dilemma of Determinism," in *The Will to Believe and Other Essays in Popular Philosophy.* (London: Longmans, Green, & Co., 1921), 328-340.

24. William James, *Pragmatism: A New Name for Some Old Ways of Thinking*, London: Longmans, Green, & Co., 1909, 118.

25. Ibid., 119.

26. Ibid., 116.

27. Harold W. Koenigsberg and Larry J. Siever, "The Frustrating No-Man's-Land of Borderline Personality Disorder." *Cerebrum* Fall, 2001, http://www.dana.org/news/cerebrum/detail.aspx?id=3372 (Accessed April 5, 2010).

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29. T.N. Monga, M. Monga, M. Raina, and M. Hardjasudarma, "Hypersexuality in Stroke." *Archives of Physical Medicine and Rehabilitation.* 67, no. 6 (1986): 415-417.

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31. Elliot M. Frohman, Teresa C. Frohman, and Ann M. Moreault, "Acquired Sexual Paraphilia in Patients With Multiple Sclerosis," *Archives of Neurology* 59 (Jun. 2002):1006-1010.

32. Dan J. Stein, Donald W. Black, Nathan A. Shapira, and Robert L. Spitzer, "Hypersexual Disorder and Preoccupation With Internet Pornography," *American Journal of Psychiatry* 158, no. 10 (2001): 1593.

33. "*Research Need.* There is a significant research-associated need to consolidate an operational definition for such a condition so that research from varying theoretical perspectives can coalesce with a common set of criteria. Such a condition has been clinically described for over 200 years in Western cultures (by authors including Benjamin Rush, MD, one of the Founding Fathers of the USA), but a specific empirically supported and polythetic set of operationalized criteria, as proposed here for DSM-V, has not been validated. In the 10th edition of International Classification of Diseases, 'excessive sexual desire' is noted but without any suggested operational criteria. A DSM-V sexual disorder associated with marked and persistent increased normophilic sexual behaviors with adverse consequences would be consistent with the aforementioned codified diagnosis. A DSM-V-based empirically derived definition should significantly enhance research efforts to explore some of the additional diagnostic validators for which there are no current data." from http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=415# (Accessed March 24, 2010).

34. T.M. Luhrmann, *Of Two Minds: An Anthropologist Looks at American Psychiatry* (New York: Random House, 2000), 8.

35. On their organization's "About" webpage, for example, NAMI states: "NAMI's support and public education efforts are focused on educating America about mental illness, offering resources to those in need, and insisting that mental illness become a high national priority. Mental illness is a serious medical illness that affects one in four families. No one is to blame. Treatment works, but only half of people living with mental illness receive treatment. NAMI has engaged in a variety of activities to create awareness about mental illness and promote the promise of recovery." http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_NAMI/About_NAMI.htm (Accessed April 13, 2010).

36. Sheila Mehta and Amerigo Farina, "Is Being 'Sick' Really Better? Effect of the Disease View of Mental Disorder on Stigma," *Journal of Social & Clinical Psychology* 16, no. 4 (1997): 405-419.

37. Jeremy Coid, "Epidemiology, Public Health and the Problem of Personality Disorder," *British Journal of Psychiatry* 182, suppl.44 (2003):s3-10.

38. Bernard Guyer, 1998. "Problem-solving in Public Health," in *Epidemiology and Health Services*, ed. Haroutune K. Armenian and Sam Shapiro (NewYork: Oxford University Press, 1998), As cited by Coid, 2003, s3-10 (see n. 35).

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43. Donald G. Dutton, *The Abusive Personality*, (New York: The Guilford Press, 2007).; Daniel W. Edwards, Charles L. Scott, Richard M. Yarvis, Cheryl L. Paizis, and Matthew S. Panizzon, "Impulsiveness, Impulsive Aggression, Personality Disorder, and Spousal Violence," *Violence and Victims* 18, no.1 (2003):3-14.

Chapter 5

Pragmatic Ascriptions of Personality Disorders: Ethical Subtheories

Introduction: Anticipating Objections

Let us now shift to more specific ethical questions that emerge from a pragmatic ascription of mental disorder. As we have come to learn from our review of Agich and Banja, pragmatic theories of disease, whether mental or physical, are both evaluative and descriptive. The evaluative component of the theory is what needs to be explicitly examined for the theory to be truly ethically defensible. Once we accept the reality that boundary cases of mental illness such as personality disorder are impossible to define in strictly naturalistic terms, we must begin to ask how and why they are defined. And as we now know, the criteria for personality disorders are by definition culturally dependent and implicitly pragmatic. Therefore, a careful examination of the motivation for deeming some behaviors as being socially dysfunctional is of central importance if we are to claim our pragmatic theory meets ethical muster. Otherwise, one could imagine a pragmatic theory that encompasses or ignores instances of potential mental disorders according the expeditious whims of the social group in power, the paucity of available resources, current medical diagnostic fads, or as a result of disease mongering efforts by powerful economic stakeholders. Thus, the set of ethical subtheories or considerations presented in this chapter aims to create a set of ethical parameters within which pragmatic ascriptions of mental disorder should occur.[1]

Each ethical subtheory will also aim to head off at the pass several anticipated objections and concerns that might be voiced about pragmatic categorizations of behaviors. These objections have their roots in those objections we have already seen in

response to naturalistic nosologies by strong normativists. From this side, there are those that argue the medicalization of personality types as 'disorders' is simply a social control scheme. Some of those who posit this objection, the so-called anti-psychiatrists, as we now know, reject even core cases of mental illness as nothing more than mythology engineered to enhance and expand prevailing power structures. It is therefore reasonable to expect that this objection would be vigorously raised against our overtly pragmatic theory for personality disorders. In considering personality disorders, for example, Szasz, not surprisingly, states:

> We are proud that we do not punish acts or beliefs that upset others, but do not injure them and hence do not constitute crimes. Yet, we punish people—albeit we call it "treatment"—for annoying family members (and others) with behaviors they deem "dangerous" and also for "being suicidal." To be sure, persons who exhibit such behaviors—labeled "schizophrenics," "persons with dangerous severe personality disorders," and "suicidal patients"—frighten others, especially those who must associate with them. Unable to control non-criminal "offenses" by means of criminal law sanctions, how can the offended persons and society protect themselves from their unwanted fellow men and women?[2]

Although he (probably intentionally) confounds core cases of mental illness with boundary cases of disorder, Szasz's worry is that the ever-expanding role of psychiatry, through the development of ideals of normal personality, will continue to intrude into the lives of those who should otherwise be considered eccentric, quirky or simply unique.

Szasz's worry is a libertarian one, which reflects his more basic philosophical commitment to strong psychiatric nihilism and the simple idea that individual liberty is constrained by the medicalization of the free choices of individuals. Conversely, this argument has also been deployed across controversies related to legal responsibility and forensics more generally. The standard Szaszian-libertarian objection to the insanity plea, for example, is based on the argument that psychiatry is itself a branch of the justice system and as such it is simply another form of social control. Szasz makes this point in a 1996 debate on the question, "Should the Insanity Defense be Abolished?":

> But let me add one other thing, which is absolutely essential: that I not only do not believe mental illness is an illness, I also do not believe that people who have not committed any crime should be deprived of liberty. I believe that the term "mental hospitalization" is an ugly, political term for incarcerating innocent people who are depressed, who are anxious, who complain about something, who have not done anything which is against the law. And this is what psychiatry is based on. The insanity defense and civil commitment are like Siamese twins. You cannot abolish one without killing the other.[3]

We can therefore predict one set of objections that would inevitably emerge against my proposed use of pragmatism to justify the ascription of mental disorder. It is, quite honestly, tempting to sideline these objections as being simply radical and extreme instances of the ravings of anti-psychiatry paranoia. However, we must take seriously these objections insofar as they forewarn the overreach of psychiatric labels and a shift away from personal responsibility toward what sociologist Peter Conrad has called "the

problem of expert control"—a dynamic defined in part by the intrusion of medical professionals who are given license to address problems of everyday life.[4] I nonetheless acknowledge that it will be a more-or-less impossible task to offer an ethical framework to fully justify my pragmatic theory to strong anti-psychiatry libertarians like Szasz. But by offering several ethical subtheories to reasonably constrain the pragmatics of psychiatric ascriptions, I shall hopefully allay some of the concerns of more moderate libertarians.

While the libertarian objection about the ascription of mental disorder might be considered a substantive objection to the basic foundations of psychiatric nosology, another set of anticipated objections would focus on the procedural aspects of the pragmatic diagnosis and classification processes. In other words, this latter set of objections would not be concerned with the pragmatic concept of mental disorder *per se*. Rather, procedural objections to pragmatic ascriptions of mental disorder would be specifically concerned about "getting it right." This is to say, the concerns of those who think that mental disorders reflect particular social biases, enhance or reinforce social controls, or covertly disenfranchise groups of individuals will demand that all pragmatic ascriptions of mental disorder pass several ethical litmus tests. These procedural concerns are what my ethical subtheories primarily aim to answer.

Let me begin with a description of what I take to be the foundational requirements needed for my pragmatic theory to be ethically applied. These foundational requirements are themselves rooted in virtue theory, which sets out key expectations that individual mental health professionals should meet. I will primarily be building off of Nancy Potter's work here. In her recent feminist philosophical investigation into the etiology

and treatment of borderline personality disorder, Potter has described several of the virtues I wish to highlight.[5] To Potter's lights, these virtues include trustworthiness, empathy, and the competency to engage in a special form of listening called 'uptake.' I will add a few virtues of my own to round out Potter's set. I will describe each of these and bundle them together into a broader pragmatic principle of beneficence.

After describing the virtues of individual clinicians, I will present the key ethical subtheories needed for a pragmatic nosology to be ethically applied at the macroscopic levels of diagnostic classification and health policy. These ethical touchstones will frame out the way in which DSM work groups, for example, should engage in thoughtful and critical reflection about the broader social and political biases that might inform their own work. In particular, procedural checks will be recommended in order to limit the influence of potentially pernicious or ethically dubious motivations driving the addition or deletion of mental disorders from the official nosology. In the next chapter, we will see how these subtheories become critical to implementing a pragmatic nosological analysis of borderline personality disorder.

Virtues of Individual Practitioners

In developing the comprehensive pragmatic theory, I emphasized the need for particular theoretical checks on the expansiveness of how the theory would be applied. Recall that a central motivation for including personality disorders within the domain of medicine was that medicine is equipped to relieve or minimize the suffering that is often associated with instances of personality disorders. For the pragmatic theory to be successful, it is crucial that it is implemented ethically and that those who directly

interface with patients—mental health practitioners—have insight and understanding about their role both as diagnosticians and caregivers. The imprimatur of an official diagnosis—one that only can be made by medical professionals—entails that medical professionals remain cognizant of both their power and responsibilities in their use of these diagnoses. While such sensitivity is important for all aspects of medicine, it is especially important in cases of boundary cases of mental illness, where the application of a diagnosis of personality disorder—defined according to pragmatic considerations—carries with it an array of political and social risks. In contrast, it is arguably the case that in oncology, infectious disease, or core cases of mental illness—that is, in clearer cases of disease and illness—the act of diagnosis will be less ethically fraught than in cases of personality disorder. This simply is because diagnoses in those cases are can be made according to a clearly naturalistic conceptualization of disease and illness.

As a reminder, naturalistic nosology provides a solid grounding for understanding and justifying the claim that a particular biological dysfunction (defined by atypical function) is a disease; those dysfunctions that have a negative impact on human flourishing are illnesses. When dealing with diagnoses of boundary cases, which I have argued should be brought into the nosology for pragmatic reasons, mental health practitioners should be expected to understand how their act of diagnosis differs ethically from diagnoses made in cases that fall more obviously within the domain of naturalistic theories of disease. We should therefore expect mental health practitioners' core set of professional skills to include several unique virtues. In discussing the ideal set of virtues of clinicians who treat borderline personality disorder, Nancy Potter makes this very point: "The aim of psychiatric treatment both medical and psychological is to restore

some autonomy, self-worth, and humanity to the mentally ill. When thinking about flourishing, then, I am including the need for clinicians to grow in virtue and self-reflection as better to work with their BPD patients and bring them a degree of flourishing in their lives."[6] In fact, we can look to Potter's work on the distinctive virtues required of clinicians who work with borderline personality disorder to serve as the foundation for our set of ethical theories complement our pragmatic theory.

As we already know, virtues represent the mean between two extremes of a particular property of character. Similarly, Potter emphasizes the Aristotelian point that virtues are not simply a set of character traits that provide a person the intellectual and moral guidance for right or good action. Virtues are also internal states of character that, as Phillipa Foot argues, manifest as actions. Virtues are, thus, expressions of "will that is good."[7] For Aristotle, Foot, Potter, and other virtue theorists, the teleological orientation of virtue theory is similar to our pragmatic theory in that, despite the moniker of 'theory', it is actually atheoretical; virtue theory prioritizes particularity and real action over intellectual appeals to abstract principles or categorical rules.

Beneficence

In contemporary bioethics, claims that invoke principles, which, in turn, justify directives about the duties or obligations of physicians, have largely supplanted ethical arguments based on virtue at least in clinical contexts. By now it is well known that the principle of beneficence, as described most famously by Beauchamp and Childress, encompasses the duties and obligations that a physician has toward her patients. Depending on which edition of Beauchamp and Childress's *Principles of Biomedical*

Ethics one reviews, the principle of beneficence applies to cases as a moral benchmark and action guide (1st edition) or as a bipartite principle that encompasses hard and soft kinds (6th edition). Although now is not the time to critique Beauchamp and Childress's four principles—there is plenty of critical literature available elsewhere—it is important to note their conceptual shift from an obligation-based principle of beneficence toward a more holistic version, which integrates, or at least invokes, substantial philosophical insights from virtue theory.

I wish to adopt a version of this more holistic principle of beneficence to ground the first ethical subtheory of the pragmatic theory of mental disorder. Beneficence will also serve as a theoretical touchstone as we move through other ethical dimensions of the pragmatic theory. To say that beneficence is a foundation of the pragmatic theory is simply to say, for our pragmatic theory to be ethically defensible evaluations of social function or dysfunction should be primarily motivated by the authentically beneficent goal of caring for people who are suffering. I should be careful to also note that reference to this principle should not be interpreted as an endorsement of specific set of hard and fast obligations, as is sometimes the classical Hippocratic interpretation.

Rather, as Dewey claims, "a moral principle...is not a command to act or forbear acting in a given way: *it is a tool for analyzing a special situation*, the right or wrong being determined by the situation in its entirety, and not by the rule as such."[8] Thus, the principle I am proposing of authentic beneficence should be thought of less as a theoretical principle and more of a meta-virtue that is derived from a person's capacity for honesty, compassion, and empathy for example. As such, it must be present or cultivated among practitioners who are engaged in the important tasks of diagnosing and

treating mental disorders. We can therefore begin to see another very practical dimension of our theory—its success depends on the actual character of those involved in its implementation and application.

Let us therefore envision attaching to the artifice of the pragmatic theory a set of virtue subtheories bundled together into a pragmatic principle of beneficence. This will be our initial step in building the comprehensive pragmatic theory. To do this, we can again look to theoreticians such as Pellegrino who posit beneficence to be the overarching principle of medical ethics, because it is internal to the practice of medicine. And again, we might adapt his theoretical perspective to fit our pragmatic need: to ensure the ethical application of the ascription of mental disorder requires individual clinicians to be motivated by genuine concern and care for the patient. We can see how beneficence is built upon several more fundamental virtues, such as trustworthiness, compassion, and integrity. Each of these virtues provides clinicians a set of ethical skills to apply the pragmatic theory across all of their key professional tasks: properly recognizing and diagnosing personality disorders and skillfully treating those disorders.

The first critical juncture in the ethical application of the theory is in the recognition and appropriate diagnosis of a personality disorder. This task is distinct from the subsequent treatment phase, which requires its own set of allied virtues. Therefore, it is important to note that, although the following virtues permeate the entire clinical encounter, they will shift in importance across the more specific junctures of the encounter. For example, as we will see in the following chapters, the skill to integrate theoretical knowledge of the norms and values implicit in the borderline label will prove most useful during initial meetings with a female client. Certainly, as I will show,

remaining cognizant of these dimensions of the disorder will be critical during the treatment phase, should the patient be diagnosed with the disorder. But on intake, the clinician should have the reflective capacity and prudence to quickly and precisely triangulate between the clinical, sociopolitical, and ethical dimensions of making an actual diagnosis.

Let us now dissect the broader principle of beneficence by discussing several of the key virtues necessary for mental health providers to work with beneficence within a pragmatically constructed nosology of mental disorders. What follows is by no means an exhaustive list. Rather, these virtues seem to me to be necessary, although not sufficient, skills that clinicians who are entrusted with the power of pragmatic ascriptions of mental disorder should possess.

Trustworthiness in Diagnosis & Treatment

Trustworthiness is a foundational concept described by Potter in her detailed list of virtues she endorses for mental health clinicians. She inventories the dimensions of trustworthiness as she builds a case for applying her virtue theory to treating borderline personality disorder. For our purposes, we will look at trustworthiness as a core virtue in the application of our pragmatic theory of personality disorders and adapt several of her key points accordingly. We will first look at how trustworthiness is crucial to the task of treating persons with mental disorders. Trustworthiness should be defined not simply as the moral capacity for individual clinicians to be trusted with information and with patient care and welfare. For example, mental health clinicians are not simply empty vaults to be used by clients or patients who entrust them with their darkest thoughts or

most vulnerable feelings during treatment. The importance of this somewhat passive form of trustworthiness, it seems, should be obvious.

When understood more accurately as an "active" virtue, however, trustworthiness can be thought of as a skill that provides clinicians the wherewithal to not only act as a genuinely loyal caregiver, but also to act appropriately within the complex milieu of clinical psychiatry. This complexity is especially heightened when working with patients who suffer from personality disorders. In this context, Potter argues that "epistemic responsibility" must be taken seriously. What she means here is that not only should clinicians cultivate their more "passive dependability but [also] an active engagement with self and others in knowing and making known one's interests, values, moral beliefs, and positionality."[9] This skill is a key to managing appropriately the dual conflicts that often emerge from relationships with patients suffering from personality disorders. As Potter points out:

> Fostering and sustaining trust is recognized as vital to the therapeutic relationship, and sustaining trust requires one to straddle an awkward midlevel position between being trustworthy to one's patient and being trustworthy to one's clinic, one's colleagues, and the psychiatric industry. Still, this in-betweenness of positionalities of power calls for maintaining trustworthiness toward one's patients and openly acknowledging the compromised position one occupies.[10]

As we will see in our case study on borderline in chapters 6 and 7, many of the ethical subtheories at work within the pragmatic theory aim to ensure that power relations are not exploited or enhanced. In both diagnosing and treating personality disorders especially,

the pragmatic psychiatrist must be trusted to be keenly aware of the particular vulnerabilities of the patient and resist the temptation, as is so often the case with therapists of borderlines, to deem them incurable or unmanageable. Such a move would be a breach of trust insofar as it would fail to provide the patient with what the patient had expected—a breach that would compromise the overall pragmatic model we are attempting to strengthen.

In a certain sense, the untrustworthy clinician is an incompetent clinician because she is more apt to misapply and misapprehend the gravity of psychiatric diagnosis and treatment. This brings us to the second dimension of trustworthiness, which actually is occurs prior to treatment: trustworthiness is crucial for proper diagnosis. The trustworthy diagnostician is skilled in his ability to apply the label of disorder responsibly, recognizing consequences of that label to the patient and other stakeholders. A better way to understand the importance of trustworthiness in diagnosis is to consider what its deficiency might cause. A failure of trustworthiness would fatally undercut our larger project of treating personality disorders as illnesses for pragmatic reasons. The virtue of trustworthiness is essential because without clinicians who are trustworthy, the first step in implementing the pragmatic theory—that is, appropriately recognizing problem behaviors, diagnosing them as mental disorders and working to relieve suffering—will prove unfeasible. This is the case for the commonsense reason that an untrustworthy clinician will at best engender little confidence and at worst suspicion and outright rejection by their clients or society at large, causing those pragmatically defined diagnostic categories to collapse under the weight of skepticism.

Already we know that the risk of this happening is more plausible for boundary cases of mental illness than for, say, cases of somatic illnesses like cancer or infectious disease. Granted, somatic diagnoses have been misused for ethically dubious ends; one need only think of how in the 1980's HIV/AIDS provided particular stakeholders with the stalking horse needed to push particular moral agendas in the name of health and safety. In these cases, however, the misuse of the diagnosis was a side effect of the diagnosis itself. When a patient was diagnosed with HIV/AIDs a set of moral and religious claims were deployed to cast judgments about the cause of disease contraction. Thus, these were judgmental overlays about of the causes of the illness and such judgments were not constitutive of the diagnosis itself.

In contrast, the very nature of the diagnoses of boundary cases in mental health makes the potential for abusive practices significantly greater because such abuses will be embedded in the definition of the disorder itself. For example, when a pragmatic ascription of mental disorder is abused or misused, the actual diagnoses and their related symptoms include the abusive assumptions. This point will become clearer as I describe additional ethical subtheories and illustrative cases. We shall see in historical examples how public trust was misused or squandered in the name of social control, profit, gendered power structures or medical-moral brinksmanship. For now, to be clear, what I simply propose is that a robust concept of trustworthiness can stand as a bulwark against various sorts of abuses that are possible with pragmatic ascriptions of mental disorder.

Some will argue that the ideal of trustworthiness sketched above is simply impossible to achieve and it is unlikely that pragmatic ascriptions of mental disorder can happen without some amount of abuse of misuse. In setting out the larger pragmatic

principle of beneficence, instantiated here by an ideal of trustworthiness, as a necessary ethical standard by which clinicians should make pragmatic ascriptions of diagnosis, we set ourselves up for inevitable failure because such a standard it is patently unrealistic and it creates standards that are unachievable. Moreover, opponents might also argue that such ideals render the pragmatic theory anything but pragmatic.

At first glance, this objection seems reasonable. After all, how can our pragmatic theory be expected to succeed if it, in turn, relies on a set of ethical standards that are both unrealistic and unachievable? However, this objection fundamentally misses the mark on exactly what I am proposing in setting out this ethical subtheory in particular and the entire set of subtheories more generally. Trustworthiness is not a transcendental ideal. It is not a quality that should be measured against a standard of perfection. Rather, trustworthiness is a particular moral skill that might be achieved in various degrees by individual clinicians. By projecting onto my proposal an expectation of perfection, the objection implicitly concludes that my proposal is one that is based on the moral principle of veracity instead of the virtue of trustworthiness.

This implication is of course incorrect. By proposing the virtue of trustworthiness as the basis for our first ethical subtheory, we build into that that theory some room for error. There is no expectation that every individual clinician would in fact be trustworthy. This is an unfortunate but inevitable reality. Rather, what the subtheory proposes is that there should be a critical mass of trustworthy clinicians, who can provide enough confidence in the overall system of pragmatic diagnosis and treatment, and police themselves to sanction clinicians who are not trustworthy. Achieving this critical mass will require policy mechanisms and pedagogical improvements, for example. Moreover,

achieving such a level of trust will require our next virtue, which is closely allied with trustworthiness. The capacities for moral insight will provide clinicians the skill to both understand their own motivations and act with integrity in making transparent these motivations.

Insight in Diagnosis

In addition to being trustworthy, a clinician who is authentically beneficent possesses two well-developed and complementary capacities: the ability to be self-aware and the will to engage in ongoing self-reflection. These key capacities will help the practitioner remain cognizant of their own biases—whether they are scientific, philosophical, social, or political. The importance of these capacities among individual mental health providers cannot be overstated because the diagnosis of a mental disorder is a profound ethical choice. In addition to having the ethical dimensions of any medical diagnosis, psychiatric diagnoses are particularly ethically fraught. They involve weighing what are often significant costs and benefits to the patient; it includes the determination of how best to manage medically—and possibly coercively—the behaviors of a person who is in some way rendered vulnerable to the powers of the institutions of medicine and the state. Thus, to reiterate, diagnosis in psychiatry must be done especially carefully.

As Reich argues, "It is the prerogative to diagnose that enables psychiatrists to commit patients against their wills, that delineates the populations subjected to their care, and that sets in motion the methods they will use for treatment. And it is therefore this prerogative that should provoke perhaps the most fundamental—and, consequently, the most serious—ethical examination."[11] All of the ethical problems—the biases and

misapplications—of psychiatry more generally, which we will encounter in the following case studies, boil down to individual acts of diagnosis. It is in the action of labeling individual patients that nosological categories are brought to life, one patient at a time.

Moreover, a misapplication of psychiatric diagnoses becomes tempting for all sorts of nonmedical reasons. Reich argues that psychiatric diagnosis is particularly seductive because it possesses a "fetching beauty" and transforms "the fright of chaos into the comfort of the known; the burden of doubt into the pleasure of certainty; the shame of hurting others into the pride of helping them; and the dilemma of moral judgment into the clarity of medical truth. [D]iagnoses can do such things in efficient and powerful ways; and the fact that they can makes their use by psychiatrists for such ends remarkably irresistible, enormously unrecognizable, and, in the final analysis, utterly human." [12] The ethical dimensions of discrete acts of diagnosing a patient as mentally ill have broader significance when we consider the overall human enterprise of psychiatric classification. A comprehensive pragmatic theory of mental illness must therefore offer guidance to the professionals—such as DSM work group members—who are involved in developing or refining classification schema. The virtue of insight will empower clinicians to critically reflect on their use of pragmatic diagnoses, particularly their motivations, and how those motivations are in or out of synch with the needs of patients.

Uptake, Empathy, & 'World-Traveling' in Treatment

Related to the virtue of insight are the concepts of uptake and empathy, which are central to Potter's analysis. These concepts will round out our list of core virtues of clinicians who work with patients suffering from personality disorders. Essentially the capacity for uptake will enable clinicians to fully engage empathically with the patient in

her time of distress while simultaneously maintaining a safe clinical distance, which is crucial in cases of personality disorders such as borderline. For our purpose, this virtue will aid in assuring the ethical application of a pragmatic ascription of disorder to constellations of behavior that are deemed dysfunctional because it will shift the descriptive weight of the ascription to the patient herself. By this I mean that a clinician will not project onto the patient expectation about how or why she is behaving in ways that cause her suffering. Rather the clinician skilled at uptake will inspire a conversation about the nature of the patient's suffering to "come off" in a way that enables the patient to fully describe the set of behaviors and accept that they are the source of chronic mental or emotional anguish.

Potter explicates this virtue in terms of basic concepts in philosophy of language. According to J.L. Austin, speech acts are a particular kind of action that require a particular form of acknowledgment of the listener for the action to 'come off'. In the case of making a verbal promise, for example, Austin argues that for such an act to hit its mark, the speaker places himself or herself under an obligation to the listener who must likewise provide recognition of the promise. In the context of anger often encountered in cases of borderline disorder, Potter refers to Marilyn Frye's application of Austin's philosophy. Frye states, "being angry at someone is somewhat like a speech act in that it has a certain conventional force whereby it sets people up in a certain sort of orientation to each other; and like a speech act, it cannot 'come off' if it does not get uptake."[13] Potter points out that uptake is required for therapists to fully understand a borderline patient's angry behavior; otherwise it is tempting for the therapist to simply cast the behavior in terms of petulant childish behavior or primitive defensiveness without

attending to the actual circumstances that may in fact give rise to the behavior. Indeed, as we know from our previous discussion, dysfunctional habits are not created *de novo* but are borne out of complex circumstances that may or may not be within direct control of the patient. A central characteristic of the capacity for uptake is to attempt to "genuinely understand the communicant's point of view."[14] Uptake is therefore critical for the ethical application of our pragmatic theory because it ensures the claims of patients are not simply reduced into one-dimensional sound bites that match up with bullet points in the a diagnostic manual or examination checklist.

Rather, uptake ensures that these claims are respected at a more intimate level—and indeed this may require some personal risk-taking by the therapist who might actually provide strategic self-disclosure to ensure their patient's claims receive proper validation. With borderline patients, selective self-disclosure is inevitably fraught. Nonetheless, selective self-disclosure performed by a skilled therapist should be considered a dimension of uptake. It allows alliance building to take place and moreover, helps the sufferer feel "real" thereby addressing an often-heard limitation in the capacity of the patient to understand the consequences of their actions on others. As psychiatric researchers Wilkinson and Gabbard explain, a limited kind of self-disclosure is appropriate and should be narrowly defined in terms of "clinical honesty." [15] The various nuances of strategic self-disclosure and the transference-countertransference dynamic are too complex to address here. Suffice it to say, clinical honesty possibly in which the prudent use of self-disclosure enhances uptake is another skill that will ethically bound pragmatically motivated diagnoses.

Additionally, we should not confuse the concept of uptake with our folk understanding of the concepts of respect or respectfulness. This is a critical distinction Potter makes. First, she says, it is unclear that respectfulness should be considered a virtue at all. Rather, it seems, respectfulness should be considered simply a necessary disposition for being a minimally decent human being. Also, it might be the case that particular species of respectfulness are themselves virtues (such as deferential respect or self-respect), but the basic concept of respect doesn't seem to entail anything more than what we should expect from others or what we in fact owe others by default. In contrast, uptake is the capacity to be not only respectful to another person but also remain fully attentive to the needs and words of that person. In the clinical context, this capacity is critical for cultivating the trust a patient must expect from their therapist in order to make therapeutic progress.

A note on empathy: although above I mentioned them in the same breath, for Potter empathy is distinct from uptake. Potter argues, in part, that empathy should be characterized as a cognitive-emotional disposition, while uptake is an actual dialogical capacity for a constructive conversation. Empathy, as a virtue, resides in the domain of 'feeling-with others and morally attentive place-taking of others' and it is marked by the capacity to shift perspectives and connect on an emotional level. As Potter suggests, "If clinicians are going to engage with their patients genuinely, they need not only to know intellectually what sorts of attitudes are helpful, but also to learn to have appropriate feelings for their BPD patients."[16] Potter provides a detailed description of how empathy has been theoretically constructed and how those theoretical constructs might dovetail with the therapeutic goals of treating borderline. For our purposes, we should take special

note that empathy is a unique virtue that should be subsumed within our broader pragmatic principle of beneficence. Although Potter breaks it out as a distinct virtue, it seems reasonable to position empathy as a midlevel virtue that should motivate and strengthen one's capacity for uptake, which in turn will support trustworthiness.

Related to empathy is the concept of 'world traveling' described by feminist philosopher María Lugones. This concept refers to one's ability to shift away from one's own 'world'—which should be understood as the full set of experiences that constitute our understanding of ourselves—to exist fully another world. The metaphor points to not simply a change one's understanding of another culture or perspective, but of a fundamental epistemic transformation in one's own identity, much the same as one might experience after a visit to or living in a foreign land. This may occur unintentionally, as Lugones suggests, because world travel is not simply a matter of acting differently in various contexts. Rather, world travel is a radical shift in attitude, possibly even contradictory to one's former attitude. To world travel requires a level of "playfulness" by which a perceiver crosses over to a new world or domain of discourse (game) and plays by new rules or no rules at all.

An interesting dimension of world-travel is that it requires one to reject what Frye has called "the arrogant perception" of normalcy. For Frye, arrogant perception is a form of evil and fundamentally coercive trickery. The arrogant perceiver, through a redefinition of terms like normal, healthy, or sane, takes control over those he perceives to be flawed and reframes facts to support this coercive worldview. This often occurs across the power divide between the clinician and patient, or between the nosologist and the subjects of study (i.e. those who present the symptoms of interest for classification).

So it is important that we emphasize here that arrogant perception is another pernicious deficiency (in the vicious sense) that will undermine the implementation of our pragmatic theory. What is necessary instead is what might be called "humble perception" as a characteristic of empathic uptake. It is marked by a willingness of clinicians to accept the possibility that, while they might have a robust and expert theoretical understanding of psychiatry, psychology and medicine, they should approach each new individual case with the curiosity of a novice.

Circling back to our central concept of uptake: in agreement with Potter and for purposes of our implementing our pragmatic theory, I believe the virtuous capacity for uptake should be considered to be fundamentally an "epistemic responsibility." Clinicians must be capable *knowers* of their patients' behaviors and juxtapose that knowledge with their understandings of social power structures and conventional norms. Linking uptake up with the virtue of insight—which itself is an epistemic responsibility to know oneself—a clinician should be able to both absorb the patient's perspective while simultaneously remaining cognizant of influences and biases that might skew their diagnosis or treatment plans. In the end, the capacity for uptake acts as an important check on pragmatic ascriptions of mental disorder because it pushes clinicians to maintain a nonjudgmental, albeit reasonably critical, perspective of their patients' accounting of behaviors of concern. Uptake, when tempered by empathy, clinical honesty and humble perception, should allow clinicians to engage in a pragmatically motivated diagnosis thoughtfully and only after fully grasping their patient's perspective.

Macroethical Considerations

The above virtues can be broadened to apply to the important and ethically fraught task of developing psychiatric nosologies. Again, as Agich has argued, decisions about psychiatric categories (as with any categories of illness) are evaluative and as such are instances of situational ethics. Thus, for psychiatric consensus panels and working groups, a central goal will be to be crystal clear about the intentions and motivations of their project. I have been arguing that, from a pragmatic perspective, the development or elimination of categories of mental disorders should primarily serve the goal of minimizing the suffering of individual patients, the broader community, and support social progress in a very general sense (e.g. through a conceptual shift away from the vice/mental illness dichotomy). The next series of philosophical-ethical considerations will help keep our primary goal in full view as well as serve as a check on ulterior motivations.

Critical Theory & Pragmatism

The ethical difficulties of diagnosing individual patients are magnified when we consider the development of psychiatric classifications. To illustrate these worries, Reich distinguishes between purposeful and unintentional misuse of psychiatric diagnosis. He describes the well-known and infamous case of sluggishly progressing schizophrenia, which was an invention of Soviet psychiatry (specifically the Moscow School), as an example of purposeful creation and misuse of a diagnosis. As late as the mid-1980s, Soviet medical publications described various new forms of schizophrenia, distinguishing it from the mainstream form of schizophrenia found in Europe and the US. Both research papers on Soviet brands of schizophrenia and the number of 'patients' had continued to

increase dramatically through the 1970's and 80's. All this despite accounts by hundreds of activists, and evidence from investigations by groups like Amnesty International, that their incarcerations were a result of their anti-government political activities, and not a medical condition at all.

This episode speaks not only to the possibility of intentional misuse of psychiatry for political ends, but also to the complexity in the way such a dynamic may occur. At the time there were psychiatrists in the USSR who genuinely believed that the category of sluggish schizophrenia was properly constructed, scientifically valid, and that dissident behaviors may have been a legitimate symptom of such a disorder. Moreover, in 1983, the World Psychiatric Association published its list of subtypes of schizophrenia, which included the subtypes used by Soviet psychiatry. The insidiousness of the Moscow School's brand of schizophrenia eventually led to a psychiatric regime within which "psychiatrists who used this diagnostic system systematically tended to diagnose as ill—and, often, genuinely to *see* as ill—persons who would not be diagnosed as ill anywhere else."[17] Thus, our pragmatic theory must be armed with the epistemic apparatus to turn a critical eye on the prevailing standards of mental illness and to step outside of the scientific paradigm guiding psychiatric classification.

Such a perspectival shift is critical for addressing unintentional or gradually occurring misuses of psychiatry. Such misuses may be shrouded by social trends and obscured by larger social structures from which they emerge. For example, as Peter Conrad has chronicled, the medicalization of hyperkinesis (the original name for what we now call ADHD) was due in large part to the structure of educational institutions, where attending to the individual needs of "hyperactive" students was increasingly challenging.

The diagnostic slippage that occurred was thus difficult to recognize other than in hindsight. This dynamic will be discussed in further detail below, as we discuss the ways disease-construction can occur within the complex structure of economic, scientific, and moral influences that constitute contemporary medicine's place in Western culture.

For the pragmatic ascription of mental disorder to be ethically justifiable, working groups need to have the knowledge and will to critically examine the history of psychiatry, which is rife with examples of abuse and misuse. It is therefore incumbent on the professionals involved in nosology to be ever vigilant of not repeating these abuses. Thus, historical and sociological data must be integrated into the scientific evidence base that is going to be used during the construction or alteration of mental disorders. Such investigations compose what I mean by a pragmatic critical theory. Here I am not necessarily referring to the exclusive deployment of *the* Critical Theory, i.e. the philosophical and sociological work of Adorno, Marcuse, Habermas, et al. Indeed, the critical theory to which I refer should be pragmatically oriented and both descriptive and normative. It should be eclectic and draw methods in critical race theory, feminist philosophy, economics, healthcare policy or any other field that might provide evidence of how prevailing ideologies or power structures impinge on efforts to add or delete mental disorders from the nosology. In fact, methods borrowed from fields such as critical literary theory should play a part in this analysis. As we will see, the metaphorical representations of borderline personality disorder in literature, movies, and poetry have influenced the categorization and reinforced the prevailing beliefs surrounding borderline women in particular.

Such beliefs will be the result of philosophical views about core concepts in psychiatry. For example, most clinicians who are products of the Western liberal philosophical tradition subscribe to a particular understanding about the nature of the self as being an independent and largely atomistic entity freely existing in the world. As a result, their concepts about the nature of volition and choice will reflect these theoretical commitments. Similarly, one's philosophical position related to questions of free will will have obvious implications for the way in which they interpret the key concepts we previously discussed related to determining problematic constellations of behavior or habits. The point here is that the critical theory must be also turned inward—in much the same way as the virtue of insight—to ensure nosologists are aware of their own philosophical commitments. The goal is not to demand nosologists abandon their commitments but rather remain aware of objections and controversies that surround such commitments in order to arrive at a nonideological and ethically acceptable position.

In sum, the central goal of a critical theory is to provide classification reviewers and developers the needed resources to achieve an ethically defensible nosology that allows for an exposition of power structures, ideology and a plurality of philosophical commitments. Those engaged in pragmatic revisions of mental disorder categories must be on guard against less obvious and subconscious instances of ulterior motivation and the way in which prevailing norms influence their positions about classification schema. Such influences might come in the form of privileged social or political positions that fixes the standpoint or limits the perspectives from which nosologists might view a set of behaviors as a potential mental disorder. Addressing specific mechanisms by which this happens is the point of our next consideration.

Appeals to Nature, Tradition & Religious Mores

Reflected in the above comments is another underlying ethical component to the pragmatic classification of mental disorder: nosologists must remain ever cognizant of the way in which appeals to nature, tradition, and religion have been and can be used to label individuals disordered. A well-known and outrageous example of an appeal to nature in defining disease categories can be seen in the racist Antebellum disorder of drapetomania, in which pseudoscientific claims about the natural role of blacks was used to justify the construction of a disease to explain slaves who attempted to escape. Other diseases such as *dysaethesia aethiopica* (or 'rascality') was attributed with causing laziness in slaves, and remedied by at first gentle coddling but culminated in whippings for 'refractory' cases. Of course, arguments from nature about racial or gender differences have been used to justify any number of mental disorders from hysteria to drapetomania.

The classic example of an appeal to traditional religious mores about sexuality can be found in the labeling of homosexuality as a disorder in the early editions of the DSM. While the arguments for inclusion of homosexuality in the DSM were framed in terms of functional or biological appraisals, historical evidence suggests these arguments were motivated more by an appeal to traditional values as extensions of religious dogma. In his book, *Homosexuality and American Psychiatry: The Politics of Diagnosis*, Ronald Bayer has charted the transformation of homosexuality from a "moral abomination" to a mental disorder; a transformation that occurred throughout the development of psychiatry from Freud to modern scientific psychiatry.[18] Notwithstanding continued controversy,

Bayer and others have convincingly shown that the justifications used to include homosexuality in the DSM were cleverly (or not so cleverly) shrouded assertions about traditional values about 'natural' sexuality, all deployed under the guise of Freudian theories about "pathologic parent-child relationships and early life situations." These justifications held up despite the fact that gay people did not feel "dis-ease" or discomfort. Only after the work of Havelock Ellis, Magnus Hirschfield, and Alfred Kinsey challenged the prevailing ideology about sexuality were gay activists able to engage in a sustained and ultimately successful political movement to remove homosexuality from the DSM. The demedicalization of homosexuality subsequently resulted in a panoply of civil rights legislation protecting gay people from discrimination, invasions of privacy and violence. As Bayer points out, religious groups mounted quick and vigorous opposition to these legislative efforts because, not surprisingly, gay rights were perceived as a threat to families and traditional mores more generally. Of course, this battle continues to rage in the context of same sex marriage and gay rights more broadly.

These thumbnails are provided simply to say that for the pragmatic theory to succeed, it will be necessary to maintain a critical awareness of how seductive arguments from nature can sometimes be. Likewise, the pragmatism I am endorsing must recognize that claims based on traditional or religious beliefs permeate the politics of psychiatric classification and should be kept at bay to ensure evidence not ideology drive work in nosology. Granted, it would be unrealistic to argue that such influences can be expunged from the domain of psychiatric classification. However, the pragmatism of my theory accepts the reality of these influences and seeks to instill within individual practitioners

and, through broader policies, nosological committees the capacity to grapple with these influences.

Moral Entrepreneurship

Similar to the role played by religious groups who are ideologically driven, sociologists such as Peter Conrad have highlighted the role of "moral entrepreneurs" in the medicalization of social problems. Drawing on Howard Becker's concept, Conrad describes how moral entrepreneurs influenced the expansion of medical treatments for hyperkinesis, which we now call attention deficit hyperactivity disorder (ADHD): "There were agents outside the medical profession itself that were significant in 'promoting' hyperkinesis as a disorder within the medical framework. These agents might be conceptualized in Becker's terms as 'moral entrepreneurs,' those who crusade for creation and enforcement of rules."[19]

Particular interest groups and movements of social activism, which may reside within or outside the conventional domain of medicine, can also facilitate moral entrepreneurship. As Conrad explains, "The classic example here is alcoholism, with both Alcoholics Anonymous and the 'alcoholism movement' central to medicalization (with physicians reluctant, resistant, or irresolute)."[20] In fact, alcoholism provides a lucid example of the explicit pragmatic logic that had been used for its categorization as a 'disease'. In his well-known and controversial book, *Heavy Drinking*, Herbert Fingarette chronicled this transformation of alcohol use from social problem to a disease. He noted that within the scientific literature arguments were promulgated in favor of

medicalization of alcohol dependence for the mere sake of social utility. He cited several primary sources. Here are two examples:

> (1) In specific circumstances it may be desirable for sociocultural, legal, political, and therapeutic goals to label alcohol dependence as a "disease," perhaps especially at the time of acute physical symptomology. At the same time the alcohol-dependent person may appropriately be labeled as "sick"
>
> (2) Calling alcoholism a disease rather than a behavior disorder, is a useful device both to persuade the alcoholic to admit his alcoholism and to provide a ticket for admission into the health care system.[21]

Fingarette argues that another driver of the 'alcoholism-as-disease charade' was the passivity of a public who maintained a convenient trust in science to solve the problem of heavy drinking. He states that it is simply easier to label alcoholism a disease rather than explain or study the complex physiological, psychological, social and cultural causes of the behaviors in question. "Our hunger for technical breakthroughs is readily fed by the hand of those who promote the classic disease concept." The mainstream media propagates this cycle. First news sources misreport scientific results as verging on a veritable breakthrough; the public quickly forgets such claims, only to be suckered into believing a new claim that replaces the previous unfulfilled promise of breakthrough. This dynamic plays out time and again and, as a result, Fingarette claims our misplaced trust and hope in scientific solutions what are actually complex social problems is reinforced. In this sense, media outlets serve as entrepreneurs who shill false promises in the name of scientific progress.

Of course, Fingarette's skepticism could well be overstated. But we should take note of the way in which he singles out social forces that influence the way diagnostic categories coalesce around expectations created in nonscientific, popular, or less scientifically informed sources.[22] We should be skeptical of claims about singular solutions or treatments—whether they are medications, therapy techniques, or recovery programs—offered to remedy complex social problems. Such simplistic claims are usually a red flag that entrepreneurship is afoot. We can see with personality disorders—as they become more and more mainstream in the popular press and self-help literature—there is a risk of this dynamic occurring as well. For an ethically justifiable pragmatic approach to addressing the problems caused by personality disorders, carefully interpreted empirical evidence will prove essential for determination of both categories and ongoing research priorities into treatments.

Another example of ostensible moral entrepreneurship is the action of the National Alliance for Mental Illness to recognize boundary cases of mental illness as equivalent somatic diseases. As I mentioned in the previous chapter, NAMI has explicitly stated that mental illness represents a disease that is outside the control of the sufferer and that mentally ill patients are not to blame. This claim is reasonable when we consider core cases of mental illness but is much more controversial when we consider how sufferers of boundary cases like narcissism or borderline may or may not have control over their actions and choices. Should it be the case that suffers of personality disorders are completely exculpated for the distress they cause to other people? NAMI's position seems to indicate such a no-fault disposition is the only justifiable way to approach such cases.

This conceptual approach to mental disorder represents moral entrepreneurship precisely because it dichotomizes questions about personal responsibility and mental illness by invoking the power of disease ascriptions as it also implicitly endorses a particular worldview about the way suffers of personality disorder should be expected to behave. It may in fact be the case that the no-fault policy is in fact the best way to manage personality disorders, as I myself have suggested when discussing issues related to personal responsibility. But NAMI's reasoning is flawed, at least from a pragmatic point of view because it relies on the false dichotomy that views psychiatric disorders as mutually exclusive from other behaviors that are within mentally ill patients' control. Ironically, this position undercuts their other advocacy efforts to provide and ensure mentally ill people with protections to make important personal and civic decisions from informed consent to voting.

Disease Mongering & Conflicts of Interest

Related to moral entrepreneurship is the role of everyday financial entrepreneurship in the expansion of medical categories. It is now well known that the professional integrity of psychiatry has been seriously eroded by its financial relationships with pharmaceutical companies. The general claim is that because so many professional psychiatrists have financial ties to the makers of pharmaceuticals, psychiatric categories have been generated or current diagnostic categories are expanded simply to maximize the sale of drugs. In fact, an entire subfield of medical social science has emerged—complete with special editions of journals and an annual conference—that

is focused on exposing instances of "disease mongering."[23] Empirical research suggests these worries are well founded.

Pfizer's redefinition of erectile dysfunction and the marketing of Viagra represent a paradigm case of disease mongering. This was accomplished first by reconceptualizing the parameters of erectile dysfunction through a very broad interpretation of the 1993 NIH consensus statement on ED, which stated that there millions of men suffered from ED, though that was at best a wild guess because of a paucity of epidemiologic data. Nonetheless, Pfizer claimed that "more than half of all men over 40 have difficulties getting or maintaining an erection" This claim was undoubtedly based on a widely cited paper in the New England Journal of Medicine which confounded epidemiologic data to claim 20-30 million men in the US suffer from the disorder. We should note that the author of this particular paper, Dr. Tom Lue, disclosed receiving grants and consultancy pay from Pfizer and a half dozen other pharmaceutical companies.

There are too many examples like Viagra to discuss here. But in psychiatry, the problem is especially grave. From ADHD to bipolar disease, the role of pharmaceutical corporate interests have had a profound influence on everything from school board policies and pedagogical best practices to prescribing patterns of antipsychotics for children as young as 3 years old. As Phillips has shown, the role of the pharmaceutical company in schools has expanded through the "in kind" support and the provision of curricular materials in much the same way doctors receive "educational literature." In 1997 Novartis, the maker of Ritalin, in collaboration with the National Association of School Nurses, provided 11,000 school nurses a "resource" kit that included resources on ADHD and how to treat it with direct links to Novartis drugs.[24] This should not be a

surprise, as it is now generally accepted that Ciba-Gegy (now Novartis) founded the advocacy group Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD). CHADD continues to receive about a third of its annual income directly from pharmaceutical companies.[25] And now there are direct-to-consumer TV ads about adult ADHD that points viewers to a site to get free info (http://www.adhdactionguide.com). The site is created by the pharmaceutical company Shire, makers of Adderall.[26]

A 2008 study by Colgrove, et al. called attention to DSM work group members who have financial ties to pharmaceutical companies. They noted that 56% of DSM panel members have financial ties, and in some specialties like mood disorders 100% of panel members had financial ties. The findings of this study were widely publicized prompting a number of articles in the popular press. Indeed the concern about conflicts of interest has become so great that Congressional leaders have started to investigate.[27] While it is true that the correlation of members' financial interests and their work on psychiatric classification does not necessarily entail that those interests caused the creation of medical categories, it is nonetheless critically important that the pragmatic theory must ensure public trust by forestalling both the appearances of and actual conflicts of interest between psychiatry and the pharmaceutical industry. Public trust is essential if medical categories are to be taken seriously.

Trust can be achieved in part through greater transparency of financial ties, as well as setting limits on amount of money individual psychiatrists are allowed to earn through by way of contracts with drug makers if they are to be part of a DSM task force. Indeed, the current DSM-V task force has attempted to take seriously the need for transparency and compensation limits and has set out a strict set of guidelines for task

force members. Unfortunately, the numbers culled from the Cosgrove study reflect the failure of these guidelines to inspire hope in the objectivity and trust in the authentically beneficent motivation of psychiatric nosologists. Policy suggestions for how to address this very significant problem will be described in chapter 8.

Psychiatric globalization—or the tendency for American or western concepts of mental disorder to spread across the globe displacing indigenous concepts of normalcy and mental disorder—represents another ethical concern closely related to moral entrepreneurship and disease mongering. In a recent *New York Times* article, Ethan Watters describes the dynamic wherein American ideas about mental illness—and those illnesses themselves—actually spread across the globe, in much the same way as a virus:

> Western drug companies dole out large sums for research and spend billions marketing medications for mental illnesses. In addition, Western-trained traumatologists often rush in where war or natural disasters strike to deliver "psychological first aid," bringing with them their assumptions about how the mind becomes broken by horrible events and how it is best healed.

As a result, Watters contends, American psychiatric categories are crowding out other cultures' understandings of the meanings, causes, and significance of mental disorders. What this process illustrates is the profound and widespread impact American ascriptions of mental disorder can have. The pragmatic nosologist must keep these concerns in mind by recognizing that the creation, alteration, or elimination of a diagnostic category is an ethical decision with far-reaching ramifications.

Conclusion

The goal of this chapter was to sketch the ethical components of the comprehensive theory. The first set of ethical considerations applies particularly to individual clinicians and can be thought of as core virtues that enable the diagnosis and treatment of mental disorder deemed as such for pragmatic purposes. The second set of ethical considerations applies more broadly to the nosological enterprise considered as a whole. It is true that such macroscopic perspective might be overly simplistic—after all, broad movements of medicalization are incredibly complex and caused by countervailing and often contradictory social forces. Nonetheless, the macroethical considerations proposed here should be thought of as conceptual proposals or touchstones used to guide the classificatory efforts of DSM task forces. In general, then, the subtheories and considerations presented in this chapter are proposed as critical elements that should guide the application of the pragmatic theory when considering whether a constellation of behaviors is a mental disorder or not. They serve as checks on the process of medicalization as well as ethical touchstones in the reexamination of current psychiatric categories. These ethical considerations, among others, will be more fully illustrated in the next chapter, as we apply our comprehensive pragmatic theory to the case of borderline personality disorder.

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1. A note on my terminology: I use the terms 'ethical subtheory' and 'ethical consideration' interchangeably to refer to specific sets of arguments, paradigm cases, or methods of analysis that I believe are needed to circumscribe the pragmatic theory within ethical bounds.

2. Thomas Szasz, "Psychiatry and the Control of Dangerousness: On the Apotropaic Function of the Term 'Mental Illness,'" *Journal of Medical Ethics* 29 (Aug. 2003): 227-230.

3. Excerpt from *DebatesDebates*, a nationally-broadcast public television show produced and directed by Warren Steibel at HBO studios in New York City. This show, entitled "Should The Insanity Defense Be Abolished?," was taped on August 26, 1996. Show #110 transcript accessed on April 1, 2010 via www.szasz.com/insanity.pdf

4. Peter Conrad, "The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behavior," *Social Problems*, 23, no. 1 (1975): 18.

5. Nancy Nyquist Potter, *Mapping the Edges and the In-between: A Critical Analysis of Borderline Personality Disorder* (New York: Oxford University Press, 2009).

6. Ibid., 7.

7. Ibid., 124.

8. John Dewey, "Moral Judgment and Knowledge," in *The Essential Dewey Volume 2: Ethics, Logic, Psychology* ed. Larry A. Hickman and Thomas M. Alexander, (Bloomington, IN: Indiana University Press, 1998), 338.

9. Potter, 2009, 129.

10. Ibid., 128.

11. Walter Reich, "Psychiatric Diagnosis as an Ethical Problem" in *Psychiatric Ethics* 3rd ed., ed. Sidney Bloch, Paul Chodoff, and Stephan A. Green (New York: Oxford University Press, 1999), 193.

12. Ibid., 205.

13. Marilyn Frye, *The Politics of Reality: Essays in Feminist Theory*. Freedom, CA: Crossing Press, 1983), pg. 88.

14. Potter, 2009, 141.

15. Sallye M. Wilkinson and Glen O. Gabbard, "Therapeutic Self-Disclosure with Borderline Patients," *Journal of Psychotherapy Practice and Research* 2, no.4 (1993): 282-295.

16. Ibid., 171-172.

17. Reich, 1999, 197.

18. Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis* (Princeton, NJ: Princeton University Press, 1997).

19. Howard S. Becker, *Outsiders: Studies in the Sociology of Deviance* (New York: The Free Press, 1973); Conrad, 1975, 12-21 (see n.4).

20. Peter Conrad, "The Shifting Engines of Medicalization," *Journal of Health and Social Behavior* 46, no. 1 (2005): 3-14.

21. Herbert Fingarette, *Heavy Drinking: The Myth of Alcoholism as a Disease* (Berkeley, CA: University of California Press, 1988), 26.

22. Importantly, for Fingarette, these forces don't carry the weight of his argument, which actually refutes the empirical claims and assumptions that alcoholism is a disease.

23. The Inaugural Conference on Disease–Mongering was held in 2006 in Newcastle Australia. See also: *The PLoS Medicine Disease Mongering Collection* available online: http://www.ploscollections.org/home.action (accessed February 19, 2010)

24. Christine B. Phillips, "Medicine Goes to School: Teachers as Sickness Brokers for ADHD," *PLoS Med* 3, no.4 (2006): e182. doi:10.1371/journal.pmed.0030182

25. CHADD's 2009 annual statement reported 35.9% of total revenue was from the support of pharmaceutical companies Eli Lilly, McNeil, Novartis, and Shire US. http://www.chadd.org/Content/CHADD/AboutCHADD/Reports/default.htm (accessed May 1, 2010)

26. Tom Tomlinson, pers. comm.

27. Mark Moran, "Senator wants APA records of drug-industry interactions." *Psychiatric News* 43, no. 16 (2008):1-3.

CHAPTER 6

AN ETHICAL-PRAGMATIC RECONSTRUCTION OF BORDERLINE PERSONALITY DISORDER (PART I)

Introduction

In the previous two chapters, I described what I take to be a pragmatic theoretical extension of a naturalistic nosological theory. I offered this pragmatic theory to help categorize personality disorders, which were described in terms of problematic and pervasive constellations of socially dysfunctional behaviors (habits), and which cause a form of suffering that intersects with the ameliorative goals of psychiatry and clinical psychology. As I emphasized in previous chapters, this pragmatic theory, although built off of a naturalistic model, does not necessarily depend on clear biological correlates to justify the ascription of mental disorder to a problematic constellation of behaviors. Rather, the justification comes from an acknowledgment that the behaviors are both socially dysfunctional and cause suffering either to the patient or to others or both. When considering the harm caused to others, I proposed using a public health model to link personality disorders to the other forms of mental illnesses oftentimes experienced by those who have close relationships with persons with personality disorders.

In Chapter 5, I explicated several important ethical subtheories and considerations that undergird an ethical pragmatic theory of mental disorder. I argued that subtheories would operate across two very broadly defined domains: that of the individual mental health clinician and that of the profession of psychiatry and psychology where nosological categories and treatment standards are established, validated, and refined. Recall the key ethical demands placed on individuals turned on a set of virtues allied with

beneficence. These included trustworthiness, insight, and the capacity for empathy and uptake. Likewise, at the macroscopic level, I argued the pragmatic theory must be bounded by several ethical checks, which aim to both recognize and prevent abuse and misuse of ascriptions of mental disorder. These checks primarily turned on a critical analysis of the power and influence of social power structures, moral entrepreneurs, traditional and religious mores, and financially motivated disease mongers.

In the next two chapters, I will more fully illustrate and apply the pragmatic theory and its ethical subtheories by analyzing the case of borderline personality disorder, which is one of ten personality disorders listed in the DSM-IV. My first step will be to offer a critical feminist analysis that exposes oppressive forces and structures that have been foundational to the standard construction of borderline. To do this, I will provide an historical sketch of the development of the standard model of the disorder. The purpose of presenting this history is to advance the ethical-pragmatic theory by showing first how the standard construction of borderline may have been built not primarily on the ethically justifiable motive of relieving mental anguish, but rather on questionable judgments regarding the proper role of women in society. Moreover, I will argue these judgments were themselves built upon a more fundamental set of philosophical assumptions about the ideal nature of the self, which has been roundly criticized by feminist philosophers as being implicitly gendered. To accomplish this, in addition to feminist critiques of liberalism and historical work on the origins of "hysteria" and "madness," I will synthesize insights from Janet Wirth-Cauchon's comprehensive study, *Women and Borderline Personality Disorder* and, again, I will draw upon Nancy Potter's recent philosophical examination of borderline.[1]

In providing this history, I will show that the standard construction of borderline serves as an anti-paradigm—to adapt a term from casuistry—to then be able to offer a way to understand the constraints within which our pragmatic theory should be applied. In other words, the standard construction of borderline provides us with an example of what an ethically impoverished pragmatic theory of mental disorder might produce: a category of mental disorder that is fraught with questionable assumptions, which in turn leads to both diagnostic schemas that reflect these assumptions and therapies that have remained largely unsuccessful. To be clear, the following historical sketch of borderline is not meant as a definitive critique of borderline disorder nor is it an attempt to argue that what is today recognized as borderline personality disorder is illegitimate. My goal is simply to use the critical literature on the history of borderline to point out how we may move forward with a more ethically justifiable pragmatic reinterpretation of the disorder's categorization, diagnosis, and treatment.

To support this line of analysis, I will describe how the standard construction has been reinforced and reflected in the ways its symptoms have been caricatured both in the professional literature and in popular venues. With such evidence in hand, it is reasonable to assert that the standard construction has been pragmatically motivated, especially in the way it enhanced and reinforced a traditional power structure, shifting blame and responsibility to the individual patient, as it helped to explain away social troubles and difficult behavior as instantiations of individual madness. Thus, the pragmatic ascription of disorder was made for the ethically deficient reasons. Again, I contend that, because of these nefarious influences and motivations, the standard construction of borderline represents an anti-paradigm of an ethically justifiable

pragmatic ascription of mental disorder. As I will show, the ethical shortcomings that are embedded within the standard construction make borderline more difficult to both appropriately diagnose and efficaciously treat.

A key juncture of my analysis will be to recognize the deficiencies of the standard construction and then to provide an ethically justifiable pragmatic reconstruction of borderline using the model I have developed. In order to respond to the problems I identify with the standard construction, in the next chapter I will apply the pragmatic theory within the constraints of the particular ethical subtheories described in chapter 5. This contextual reanalysis will reveal that the symptomatic behaviors of the borderline patient are actually somewhat understandable—they reflect the deep frustration, anger, helplessness and fear one might expect in anyone who has suffered trauma, abandonment or serious abuse. Thus, a key pragmatic distinction will be to recognize the symptoms of borderline as legitimate responses to and the sequelae of psychological and physical abuse and injury, but also as self-defeating in the way these behaviors are deployed by the patient. One goal, also described in the next chapter, will be to refine the clinical understanding of borderline's symptomatic dysfunctional behaviors so that clinicians can help patients to transform and refocus diffuse anger toward more constructive ends. Let us now critically review features of the standard construction of borderline personality disorder that cause its current categorization, diagnosis, and treatment to be both ethically defective and pragmatically suboptimal.

Basics

As I began to describe in Chapter 4, borderline personality disorder is marked by

the essential feature of "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts."[2] The DSM estimates prevalence of borderline personality disorder in the general population to be about 2%. Coid, et al. in their meta-analysis, have indicated that estimates on the prevalence of borderline range from 0% - 3.2%, depending on the version of the DSM used and diagnostic techniques. Approximately 75% of all diagnosed cases of borderline occur in females.

Persons diagnosed with borderline experience intense fear of real or perceived instances of abandonment—so much so that their behavior, affect, and cognitive habits are dramatically reactive to this fear. In their frantic efforts to avoid abandonment, borderlines might, for example, threaten suicide (8%–10% complete suicide) or self-mutilate (cutting or burning). Impulsivity dysregulation may occur as behaviors such as gambling, binge eating, substance abuse, unsafe sex, and reckless driving. Borderlines exhibit a general dysphoria, which is randomly interrupted by angry outbursts, anxiety, or panic. These outbursts, as illustrated in the vignettes in Chapter 4, often occur when the borderline person feels threatened by the real or perceived possibility of abandonment.

These core features and several associated features contribute to the borderline person's inability to cultivate and maintain long-term friendships and relationships. In particular, as one psychiatrist explained to me, borderlines tend to "glom" on to people because of their fear of being alone or abandonment. This often-aggressive behavior causes others to push borderlines away, resulting in the abandonment borderlines so frantically had tried to avoid. Typically, the borderline person will then decide their abandoner was evil in some way and this reinforces their black and white view of

others—those who are unquestionably with them are idealized, anyone perceived as a threat is considered evil. This interpersonal volatility causes borderline persons to experience instability in their professional lives as they find themselves constantly unsettled in their jobs and career plans. Persons with borderline experience significant identity disruptions and instability, which is both part of the etiology and exacerbates the symptoms of the disorder. The standard construction has defined borderline in terms of other mental illnesses as well. As Gunderson describes, in addition to including borderline on the personality disorder spectrum, researchers have suggested considering borderline as a part of schizophrenia spectrum, affective disorder spectrum, or, more recently, the bipolar spectrum.[3]

An Historical Sketch

I now wish to show that this construction of borderline disorder belies a degree of gender bias, which transformed and retransformed the disorder until it was officially recognized in 1980 in the DSM-III. To do this, let us briefly review the historical construction of borderline disorder, so that we may more fully grasp the social and value laden characteristics of the contemporary disorder. I will not review in detail the genealogical studies of the medicalization of madness vis-à-vis power structures and women's health. My central goal here is to provide enough historical background from which to then claim a bias has infiltrated the ways by which the features of borderline are characterized. This bias turns on the classically liberal philosophical concept of the self, which favors the outwardly stable, rational, unwavering male self over the unstable, emotional, and "uppity" woman and that to reconstruct borderline in an ethical way, this

needs to be recognized. Thankfully, Wirth-Cauchon, in thorough Foucauldian fashion, provides a genealogy of the three discrete "phases of meaning" that borderline has traversed, which provide us with thumbnails for this historical sketch.

In the earliest phase, the British doctor Andrew Wynter described patients existing in an allegorical borderland "who appeared neither mad nor sane, and yet who were described as socially marginal and transgressing the boundaries of Victorian social class."[4] I should note here, Wynter's description is probably based upon, at least in part, Prichard's concept of moral insanity, which was explicated decades earlier in his *Treatise on Insanity.*[5] The name 'borderline' itself depended on the traditional dichotomy between psychosis and neurosis, thus we can track that back to the 1860s and 70s. In the next section, we will turn our attention in some detail to the term 'borderline,' where we will see that the metaphorical description is an important basis for the development of the mythology of the borderline woman in conflict with the liberal self. For now, it is important to note that the origins of the modern disorder were characterized by an understanding of borderline as an enigmatic illness, residing somewhere between hysteria and sanity, which defied treatment and clear categorization.

During the second phase, the term "borderline" received its first formal mention in 1938 by Adolph Stern, who used it to classify patients that appeared to reside within the nexus of neurosis and psychosis.[6] During this phase, borderline was integrated into the Freudian psychoanalytic tradition as a disruption in basic object relations and recognition. In his later writings, Stern laments that patients on the borderline are severely and desperately ill. They happen to be an exceptionally challenging group of patients because of their tendency for transference, which occurs when a psychiatric

patient projects her feelings or emotions onto the therapist. Transference might manifest as blame of the therapist, the view that the therapist can fill the void left by an absent parent, or as sexual interest in the therapist. More importantly, the borderline patient was described as being adept at eliciting counter-transference wherein the therapist actually falls into his unrealistic transferred role and reacts to the patient from within that role. The apparent transference/counter-transference dynamic that occurred during analysis sessions made treatment of borderline so difficult as to be deemed "incurable." Indeed, the borderline label seemed to be synonymous not-so-much with a particular neurosis or psychosis, but rather with characterizing a type of incorrigible patient who was typically a woman. As Gunderson points out, during this phase, borderline was a product of the psychoanalytic paradigm, in which neuroses were 'analyzable' and psychoses were not.[7] As their name indicates, borderlines resided somewhere along that edge.

Also during this second phase, Kernberg provided the most well developed psychoanalytic account of borderline conditions, grounded on the Stern's notion that the borderline patient suffers from a disorder that is neither a neurosis nor a psychosis and, as we will see, he applied object relations theory to explain the fragmentation of the borderline individual. He subsumed his construction of borderline within the larger framework of 'hysterical' personality types, defined by emotional lability, over-involvement, the combination of dependent and exhibitionistic traits, pseudo-hypersexuality and sexual inhibition, selective competitiveness with men and women, and masochistic traits.[8]

In describing the specifics of these symptoms, two points stand out and will be revisited when I discuss the gendered dimensions of the standard construction. First,

Kernberg states that over-involvement "may appear quite appropriate on the surface. Nonsophisticated observers usually consider it in women as typical feminine charm."[9] Likewise, Kernberg says that "[h]ysterical women who tend to compete with men (in order to deny their sexual inferiority) tend to develop stable characterological patterns in this regard; in their competitiveness with other women, oedipal rivalry tends to predominate over other origins of the competitiveness."[10] Second, Kernberg's description of the transference-countertransference dynamic is also telling. He says,

> In dealing with borderline personality organization, dedicated therapists of all levels of experience may live through phases of almost masochistic submission to some of the patient's aggression, disproportionate doubts in their own capacity, and exaggerated fears of criticisms by third parties. During these phases, the analyst comes to identify himself with the patient's aggression, paranoid projection, and guilt.[11]

The upshot is that the borderline patient is so difficult that the frustration of the therapist and their defeat is a result of the disorder and is the patient's fault.

The third phase of meaning began in 1980, when borderline was officially recognized within the DSM-III as a personality disorder. The publication of the DSM-III marked a significant paradigm shift in the way in which mental illnesses, and particularly personality disorders, were described and categorized. But this shift did not come out of nowhere. As Klerman describes, the DSM-III represented a neo-Kraepelinian classification schema—a nosological structure inspired and informed by the work of turn-of-the-20th century psychiatrist (and discoverer of bipolar disorder, schizophrenia, and co-discoverer of Alzheimer's disease) Emil Kraepelin.[12] Kraepelin's nosology—itself

divided into the two categories of manic-depressive insanity and dementia praeocox—was the first attempt to build a scientifically grounded psychiatric nosology that followed the medical model by reducing mental illness to disorders of the brain, which were empirically observable, somewhat predictable in that they were shown to be heritable, and distinguishable from behavioral idiosyncrasies. The DSM-III reflected these scientific ideals in a number of ways, most obviously in the fact that it was constructed only after reliability testing and validating field trials were conducted. This was the first time medical practitioners had attempted to validate their nomenclature prior to its becoming official. This effort continued as the validation methods proposed a decade earlier by Robins and Guze—analyses that included clinical description, laboratory study, follow-up study, and genetic studies—were used to test the validity of the newly defined borderline disorder.[13]

Also, among the many important changes in the DSM-III was the redaction of psychoanalytic terms and concepts, such as the word 'neurosis,' and the elimination of homosexuality as a disease (in the DSM-III-R). But the most significant conceptual shift was the move away from the biomedical notion of a 'disease entity' that caused mental illness toward a multiaxial categorization of mental illness. In earlier versions of the DSM, personality types (i.e. hysterical personality, passive-dependent personality) were constitutive of other mental illnesses, but were not, themselves, considered disorders. In the DSM-III, personality disorders took their place within Axis II, neatly broken out from other conditions as discrete pathologies "existing concurrently with other forms of psychopathology."[14] The new multidimensional description entailed that personality assessments be central to diagnosis and treatment. By creating a clinical dimension

solely for personality evaluation, Wirth-Cauchon argues, the DSM-III working group opened up "new terrain" for medicalization of the whole person. Indeed, we see this rather clearly in the original definition of Axis II disorders: "A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability)."[15] Each of the disorders was clustered into categories that stipulated dysfunctions be assessed in the context of social expectations.

In his 1984 meta-analysis, John Gunderson describes the features of borderline across six domains—affect, identity, interpersonal relationships, impulsivity, psychosis, and miscellaneous—against which he superimposed more specific findings in the literature. Key features within the domain of affect included anger, depression, and chronic feelings of emptiness. Identity disturbance (or an unstable sense of self) was the central feature of the identity domain. Across the interpersonal relationship domain, Gunderson found that anaclitic or highly emotional, stormy, and angry interpersonal interactions were common. According to this analysis, borderlines also share features of impulsive drug and alcohol use, self-harm, manipulative suicide gestures, and 'unstable sex' (promiscuity). Although now slightly dated, this picture of borderline was culled from dozens of papers and represents the standard construction of borderline that is today still widely reiterated.[16] Later, Zanarini and Frankenburg offered a similar picture defining the inner pain of the borderline as both cognitive and affective, with its etiology rooted in traumatic early life events or abuse, which, in combination with a vulnerable or hyperbolic temperament, produced the disorder.[17]

A few years after the publication of the DSM-III, in what seems to be the first published feminist critique of the manual, Marcie Kaplan argued that the fundamental shift toward multiaxial diagnosis had been a catalyst for the institutionalization of sexist bias within psychiatric nosology. In response to the way in which personality disorders were framed, Kaplan asks,

> What does impairment in social or occupational functioning mean? I believe these criteria contain assumptions and then generate diagnoses accordingly. For instance, is a woman unemployed outside the home impaired in occupational functioning? Is a man who is employed outside the home and thus never there when his children come home from school impaired in social functioning? Evidently users of DSM-III assume not, or many "healthy" individuals who assume traditional gender roles would have diagnoses; yet a woman who neglects her children and a man who can't hold down a job—perhaps healthy individuals who assume nontraditional roles—may be labeled impaired by a diagnostician.[18]

We will consider some of Kaplan's concerns more directly below. For now, it is important to recognize that the normative assumptions built into the standard construction of borderline over the course of the past several decades had become further entrenched, more widely expanded, and officially codified with the DSM-III.

Today's DSM-IV-TR and the soon-to-be completed DSM-V mark the continued development and modification of the multiaxial system, with refinements made in response to the criticisms leveled against the DSM-III. I should note that in the proposed DSM-V, the procedure for diagnosing of personality disorders could change. Instead of

ten disorders, there will be five general personality disorder types. Dozens of personality traits (within a few trait domains) are rated according to relevance. This assessment is intended to provide therapists a general picture of their patient's personality type, even if they do not have a personality disorder. The specific boundaries for diagnosing a personality disorder within this structure have yet to be determined.

Nonetheless, the current diagnostic criteria of borderline disorder remain controversial for both philosophical and medical reasons; it is a controversy that I believe is the result of ideological biases that helped to produce these criteria. Examining the ways in which borderline women have been portrayed can help us to continue to uncover biases that are built into the standard construction of borderline. After a brief look at representations of borderline, we will shift back to the philosophical examination of how the borderline woman serves as a foil for a more fundamental philosophical standard of the rational autonomous self, which has served as the template for what constitutes the ideal of a normal personality.

Tropes & Caricatures of the Borderline Woman

Metaphor is a powerful tool often used to express the inexpressible and convey a deeper message about an individual, group, situation, or a process. As Rooney has argued, metaphors are more than "stylistic embellishments"; rather, "the metaphor reveals much more about historical background assumptions and imaginative underpinnings."[19] Metaphorically speaking, metaphors are the smugglers of normative claims. It is therefore reasonable to assert that the metaphors associated with the borderline woman reflect certain assumptions about madness, insanity, and women's

emotional instability, which also reveal gender bias that is ultimately instantiated more formally in the psychiatric nosology. Although the creative choices made to explain borderline by professionals, patients, and lay observers should not be taken as the final word on how borderline has been socially constructed, I think it is safe to assume that these choices do reveal latent assumptions and biases embedded within that construction. This is simply to say an analysis of metaphorical portrayals can serve as a starting point for uncovering implicit ideologies or motivations. This is the kind of critical analysis that is required by our pragmatic theory; this begins with the name of the disorder itself.

Recall during its early phases of meaning, we found evidence of bias in the label—itself a metaphor—of the 'border land.' As Wirth-Cauchon explains, the term borderline was a both a symbol and reflection of the lack of understanding of a certain group of patients. Citing Martin Leichtman, Wirth-Cauchon says that "the image of the borderline disorder" was conveyed as "a vast uncharted 'territory' of madness that scientific rationality discovered, explored, and demystified by bringing to it to light of scientific reason."[20] In Leichtman's words, "those who dealt with the borderline concept in this period resemble explorers, trappers, and pioneers who ventured out from more settled areas to map and cultivate an undefined wilderness."[21] They were depicted as men who were sent out to conquer and tame nature.

The picture of the borderline woman who dwells in a strange and fantastic *terra incognita* is fully painted in Christine Ann Lawson's book, *Understanding the Borderline Mother*. Lawson makes explicit connections between the relationships children have with their borderline mothers and Lewis Carroll's *Alice's Adventures in Wonderland* where, as we know, logic and reason are abandoned atop the rabbit hole. In Lawson's

words: "Like Alice in *Alice's Adventures in Wonderland*, children in Borderland are puzzled by the contradictions of their world and live on the fine line between sanity and insanity." [22] Continuing the allegory: "Children of borderlines have been down the rabbit hole. They have heard the Queen of Hearts order everyone beheaded. They have attended the mad tea party and argued with the Duchess for the right to think their own thoughts. They grow weary of feeling big one minute and small the next."[23]

Lawson characterizes borderline mothers as 'make-believe' women, whose intense fickleness and power could be intriguing if it were not so venomous. In the body of Lawson's book she goes on to cast four types of borderline mothers: the waif mother, the hermit mother, the queen mother and the witch mother. The waif mother plays the role of the helpless victim of past abuses and finds life too hard to live. She responds to oppressive environments through helplessness and resignation. The hermit mother is secluded and paranoid; she lives in fear and distrust. She is obsessive compulsive. The queen mother is self-centered, flamboyant, ambitious and intimidating. She is preoccupied with her image and that of her children. Finally, the witch mother—the most terrifying of the four—shifts in and out of the other roles, but, ultimately, she is described more-or-less as the embodiment of evil, as she summons her internal rage and anger to abuse her children and annihilate anyone she perceives to be a threat to her delicate persona. Outside of the home, Lawson describes how she divides groups, forms fleeting alliances, and ultimately feels a sense of sadistic enjoyment when those with power or authority are diminished.[24] Drawing on mythology, Lawson claims, "The Medean Mother is the most pathological (and rarest) type of witch." She lives according to the mantra, "Life is war."[25]

We also see various metaphors and caricatures of the borderline woman brought to life on television and in film. Lawson claims Joan Crawford, described by her adopted daughter Christina as emotionally and physically abusive and portrayed in the movie *Mommie Dearest*, is a paragon of the borderline mother. Glenn Close's character in *Fatal Attraction* provides a caricature of the hypersexual, violent, and jilted borderline woman whose psychotic rage is triggered after a dalliance with a married man. To my lights, the starkest example of the Medean Mother was portrayed by the character Livia Soprano, Tony's mother, who feigned senility in her attempt to murder her own son. Another borderline woman appears in later episodes of *The Sopranos* in the character of Gloria Trillo with whom Tony has a torrid affair. Although Trillo starts off as an independent, successful, and charming woman, she comes to represent an evil obsessive temptress and reincarnation of Livia. She eventually hangs herself after Tony rejects her.

In Henry Selick's animated screenplay *Coraline,* we find an exceptionally creepy version of the witch-borderline mother. Young Coraline discovers her 'Other Mother' who lives in an alternate universe, Other World, accessible to Coraline through a closeted portal that actually resembles a birth canal. Initially, Coraline is seduced by her Other Mother's warmth, charm and attention; Other Mother spoils Coraline with her favorite food and showers her with affection. Coraline eventually comes to realize the true evil of this ersatz parent when she discovers the ghosts of previously enslaved children, whose eyes and souls the viciously cruel Other Mother had removed. Fortunately, Coraline figures out a way to eventually outfox and escape Other Mother who, in their final battle scene, metamorphoses into her true form—a giant arachnid.

All of these female characters radiate their rage, spread chaos, and possess disingenuous and deeply disturbed personalities. Though they are only metaphors and caricatures, the potency of such characters defines a narrow aperture, or what Rooney describes as the "focus and frame," through which the metaphorical borderline woman is understood as "the subject of discourse" in both medicine and society.[26] Of course there are many cultural renderings of psychotic or psychopathic men. However, to my knowledge, there are no portrayals of borderline men specifically, at least none that have reached the level of popularity of the above examples. In fact, several of these well-known representations of borderline women have been used as case studies to teach young clinicians about the disorder, thereby amplifying the power of the standard construction and its corresponding tropes.[27] I therefore contend that both the historical mythology of the sick outcast of the borderland and the metaphorical descriptions of the borderline woman are actually conceptually interdependent and self-sustaining.

To continue our critical analysis we should dig a bit deeper and ask, "From where do the metaphorical renderings and historical archetypes of the borderline woman derive such explanatory power?" Let us now look at the way in which these constructions and depictions result from an even more basic philosophical assumption related to the ideal nature of the self—an ideal that, in turn, drives psychiatric classification and intervention. As I will argue, revealing and realigning these unspoken philosophical commitments is a necessary step toward reconstructing borderline within the ethical constraints of our pragmatic theory.

The Liberal Self

The goal of this section is to draw upon feminist philosophical insights to

critically examine how the liberal self as a gendered concept serves as the foundation for assessing personalities as disordered or healthy. The concept of the autonomous transcendental self, as systematized most clearly by Kant, is that of an individual moving through the world autonomously. He makes rational decisions according a set of absolute moral rules, which are *a priori* and are accessed through the apparatus of pure reason. Though some feminists, particularly Marxist and radical feminists, challenge liberalism's emphasis on individualism, other liberal feminists continue to accept, adapt, and refine the concept of autonomy to accommodate feminist concerns. Although the concept of autonomy has been augmented to answer objections that it ignores the relational dimensions of lived experience, the individualistic core of the liberal self remains solidly intact. For example, before proposing their own version of autonomy, Anderson and Honneth (2005) acknowledge the "individualistic conception of autonomy not only has historical pedigree; it also has come to seem just *obvious* to many."[28] Indeed, we often assume that for a child to develop into a fully autonomous adult means they should become independent, self-sufficient, and capable of meeting life's challenges on their own. Signs of continued dependence on others are taken as evidence of developmental delay and social dysfunction.

Similarly, the rational core of the autonomous person is a *sine qua non* of the ideal self. The capacity to make rational decisions equips an autonomous person with the necessary aptitude to correctly navigate life's complex social, ethical, and political waters. Again, some feminists have attempted to buttress the Kantian notion of autonomous decision by providing nuances that recognize the influence of oppression on "rational" choices. For example, the distinction between procedural autonomy and

substantive autonomy is one attempt to retain a concept of rationality, while simultaneously recognizing the effect oppression has on rational decision-making.[29] Nonetheless, prolific work within the canon of feminist philosophy, particularly by radical feminists and feminist historians of philosophy, has convincingly identified the split between the autonomous rational 'self' and the nonrational dependent 'other' to be a reflection and reinforcement of role expectations of men and women.

We see the classical concept of the liberal self woven throughout psychiatry, particularly within standard theories in the psychology of personality to explain the etiology of borderline. For example, object relations theory posits that the normal "psychic structure [i.e. personality] is composed of units involving a representation of self, a representation of the other in relation to self, and an affect linking the two."[30] An adaptation of Freudian psychology, object relations theory, posits that humans have an innate drive to become autonomous subjects, through a process known as separation-individuation, which then allows the mature person to enter into healthy relationships. Representations of other people are "objects" and, as Greenberg and Mitchell describe, object relations "designates theories, or aspects of theories, concerned with exploring the relationship between real, external people and internal images and residues of relations with them, and the significance of these residues for psychic functioning."[31] The normal personality structure is defined in terms of internal coherence, a recognition of the separation of the self and other, and,

> *...the capacity for mature interdependence characterized by deep emotional commitments to others* in the context of maintaining a sense of *autonomy*... The mature system of internalized values, while rooted in

> parental values and prohibitions, does not remain rigidly tied to parental prohibitions, but *becomes a stable, individualized, internal structure that exists independently of external relations with others.*[32]

Becker has criticized Kernberg's theory that borderline is caused by a short-circuiting of object relations for being little more than a sophisticated version of Freudian Oedipal theory. As a result, Becker says,

> Pregenital—particularly oral—aggression is generally projected onto the mother and, to a lesser extent, the father. The mother becomes, by this means, a dangerous and potentially destructive object, and the father gradually also becomes a screen for aggressive projection... The borderline individual, in Kernberg's scheme, remains developmentally arrested at the stage of early object relations where representations of self and other remain unintegrated.[33]

The stunted development of a fully integrated superego and 'identity diffusion' eventually cause the ego to resort to the primitive defenses that characterize the borderline patient's symptomatic inability to maintain healthy relationships. Often, it is claimed, these primitive defenses involve deceit and manipulation of others. Though not an explicit criteria in the DSM, manipulative behavior by borderline patients is a typical symptom. The borderline patient is said to manipulate everyone she encounters. She manipulates her therapist, as we saw, through the process of transference, which is said to undermine all efforts by the therapist to treat the borderline patient. As a result of their penchant for manipulation and transference, according to the standard construction the borderline patient is seen as tragically incurable. As Kernberg says,

> Many patients with borderline personality organization do not tolerate the regression within a psychoanalytic treatment, not only because of their ego weakness and their proneness to develop transference psychosis, but also, and very predominantly, because the acting out of their instinctual conflicts within the transference gratifies their pathological needs and blocks further analytic progress... Efforts to treat these patients with supportive psychotherapy frequently fail.[34]

Within the diagnostic explanations of manipulation, lying, and deception, we begin to see judgments about personal morality built into the signs and symptoms of the borderline disorder. As Clarkin, et al. explain, "Low level borderlines are relatively lacking in internalized moral values, at the extreme manifesting borderline and antisocial behavior without feelings of fear of wrong and guilt."[35] Thus, an inevitable question finally comes to the fore: Is the borderline woman inherently immoral? As we know, the borderline personality, according to the standard construction, is a fragmented and stunted version of the coherent rational self. This results in an erosion of the governance and self-management by the superego, which prevents the borderline person from appropriately relating to others. Therefore, as a dependent individual who is fated to a life of heteronomy, the borderline woman is utterly morally flawed.

To answer some of the above concerns, researchers continue to work to more objectively assess the borderline disorder using psychometric research to refine the current taxonomy (i.e. in preparation for yet-to-be published DSM-V). Weston and Shedler, for example, admit that the "diagnostic categories [of personality disorders] have their origins in clinical observation and theory...[h]owever, they have truly satisfied

neither researchers nor clinicians, including members of the DSM-IV task force itself..."[36] They have therefore worked to add more empirical evidence to the criteria for determining personality disorders and developed psychmetric tests such as the Shedler-Westen Assessment Procedure-200 (SWAP-200) to refocus the diagnostic around dimensional prototypes of each disorder. But it is possible that these more sophisticated research programs may actually rehash previous, more obviously biased, assessments.

For example, Table 1 presents a concatenation of several of the questions from the SWAP, which I have categorized according to particular dimensions of the liberal concept of the self. We see that each item can correspond to a philosophical expectation (or bias) that Winston-Cauchon and Kaplan have argued is characteristic of the overall diagnosis. In each case, we find a particular assumption or combination of assumptions about the idealized self, whether it is the independent and nonrelational self, the rational self, or simply an ideal of a deferential person who accepts a power structure without complaint. Although these items should not be analyzed as single empirical nodes, but rather viewed holistically in the context of the entire constellation of behaviors, we do find interesting examples of what feminists have identified as constituting potential 'double binds' across the individual items. For example, we see this dynamic reflected in items related to relational volatility, emotional lability and irrationality typical of the disorder defined in terms each other. Another item finds a potential symptom in women who are "ingratiating or submissive," while at the same time, "a tendency to get into power struggles" is also considered symptomatic. Consequently many women become ensnared in a diagnostic double bind.

One final anecdote on the power of words in diagnosis: the diagnostic interview

for borderline patients (DIB) has been criticized for its unintentional use of sexist (and heterosexist) terminology. In a letter to the editor of the American Journal of Psychiatry, Kenneth Zucker pointed out:

> Summary statement 25 [of the DIB] reads as follows: "[The patient] actively seeks a relationship taking care of others (e.g., nurse, veterinarian, housekeeper)..." Since the patient can be either a man or a woman, it is unclear why two of the three occupational examples (nurse and housekeeper) are those predominantly populated by women. These examples appear sexist in implying that borderline personality disorder might be overrepresented among nurses. It is obvious why this occurred: borderline personality disorder is diagnosed much more frequently in women than in men. Nevertheless, a simple change in the phrasing (e.g., "health professional" instead of nurse) would render it nonsexist but retain the underlying conceptual point that people with borderline personality disorder might be drawn to a profession that provides care to others.[37]

When terminology within the interview protocol reinforces latent biases of the standard construction, it makes it all the more difficult for clinicians to recognize and examine their own biases when diagnosing patients.

Indeed, despite the best efforts of DSM work groups, we find the fingerprints of Enlightenment social, moral, and political ideals, transmitted through object relations theory and codified in recent iterations of the DSM. Thus, to apply the pragmatic theory toward the goal of a more ethically justifiable model of borderline disorder, we must remain cognizant of how its historical, philosophical, and popular biases permeate the

current category and potentially motivate research into the biological basis of the disorder. Let us now consider how we might critically interpret data about the biological basis of borderline.

Table 1. Selected items describing patients with borderline disorder or dysthymia (including BPD patients) from the SWAP-200 assessment procedure, cross-referenced to potential gender biases that are related to the liberal ideal of the self. *(1= Failure of the rational self; 2= Failure of the individual self; 3= Failure of deferential self.)*

Borderline Patients (Conklin & Westen, 2005)	
Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, excitement, etc.	*1*
Tends to fear she/he will be rejected or abandoned by those who are emotionally significant.	*1, 2*
Is unable to soothe or comfort self when distressed; requires involvement of another person to help regulate affect.	*1, 2*
Tends to be angry or hostile (whether consciously or unconsciously).	*1*
Tends to feel she/he is inadequate, inferior, or a failure.	*1*
Tends to feel misunderstood, mistreated, or victimized.	*1, 2*
Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning.	*1*
Lacks a stable image of who she/he is or would like to become (e.g., attitudes, values, goals, and feelings about self may be unstable and changing).	*1*
Tends to be overly needy or dependent; requires excessive reassurance or approval.	*1, 2*
Tends to act impulsively, without regard for consequences.	*1*
Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring but tends to reject it when offered).	*1, 2*
Tends to express intense and inappropriate anger, out of proportion to the situation at hand.	*1*
Tends to "catastrophize"; is prone to see problems as disastrous, insolvable, etc.	*1*
Tends to feel helpless, powerless, or at the mercy of forces outside his/her control.	*1, 2*
Interpersonal relationships tend to be unstable, chaotic, and rapidly changing.	*1, 2*
Tends to feel like an outcast or outsider; feels as if she/he does not truly belong.	*1, 2*
Tends to become attached quickly or intensely; develops feelings, expectations, etc., that are not warranted by the history or context of the relationship.	*1, 2*
Dysthymic patients (includes patients with BPD)	
Are ingratiating or submissive.	*2*
Described a tendency to get into power struggles	*3*
Tends to be angry or hostile.	*1*
Tends to blame others for their own failures or shortcomings; to feel misunderstood, mistreated, or victimized.	*1,2,3*
Tends to be oppositional and contrary.	*3*
Tends to feel helpless or powerless.	*1, 3*
Tends to be suggestible or easily influenced.	*1, 2, 3*
Tends to be overly needy or dependent.	*1, 2*
Tends to fear they will be rejected or abandoned.	*1, 2*
Tends to fear being alone.	*1, 2*

Biological Function & Borderline

A key feature of the pragmatic-ethical theory of mental disorder is that it requires a critical examination of our categories of boundary cases to expose latent and ethically problematic biases. Yet some might object that the above critical discussion of borderline offers nothing more than an historical account of a mislabeling of symptoms of mental disorder, which has now been superseded and corrected by reliable empirical evidence. They might support a modified version of the standard construction by arguing that borderline is now more clearly based on evidence of biological dysfunction. Those who make this argument would marshal recent neuropsychological evidence to claim that borderline is fundamentally a set of brain-based dysfunctions that are common across all those who suffer from the disorder.

Such a move would in fact shift attention away from the long-standing definition of personality disorder, which is explicitly based on socio-cultural functioning. Likewise, this kind of objection is a derivative of the more general debate regarding the ontological nature of the concepts of health, disease, and illness. As we already discussed, naturalists such as Boorse argue disease is reducible to biological dysfunction. His biostatistical theory of disease relies on the standard of species typical functioning, against which measurements of dysfunction should be made. Functional assessments are, to Boorse, value-free empirical tallies. In the case of borderline, some argue, evidence of abnormal brain activity and morphology is now available. Therefore, it seems, we can avoid questions about past or present biases or ideological influences by strengthening borderline's standard construction with more and more neurological data.

However, such an approach is a self-fulfilling prophecy. The empirical data related to abnormal biological function assume a standard of species typicality with respect to the constellations of behaviors in question, which, at least to my knowledge, has yet to be assembled. Moreover, because the definitions of personality disorders are couched in deviations from cultural expectations, the search for a biological basis of such deviations simply ignores the possibility that those expectations are themselves problematic. We see this tendency implicitly across recent correlation studies, which are interpreted as providing causal evidence of borderline's etiology. These studies suggest borderline is directly related to genetic predispositions, metabolic and endocrine disorders, and abnormalities in brain morphology and brain lesions.[40]

In one more recent study, Evardone, et al. point out that particular hormone levels are correlated to symptoms of borderline personality. Their results indicated that "measures of hormonal change from week 1 to week 2 of the menstrual cycle, a time of follicular development and increasing estrogen levels, were associated with higher symptoms scores" associated with the borderline disorder.[41] They also cite recent evidence that borderline personality is associated with altered brain morphology in systems for emotional processing and executive functioning. Several twin studies also seem to point to a genetic basis and heritability for borderline.[42]

I certainly accept that biomedical research is critical and valuable in assessing the status of the borderline disorder. To deny a biological basis or predilection for various components of the borderline disorder would be naive and would fly in the face of compelling scientific research that links both genetic and physiological factors to core cases of mental illness. However, as we work from a critical feminist perspective—in our

effort to apply the pragmatic theory ethically—scientific data suggesting a straightforward biological basis for the complex characteristics of borderline should give us pause. Again this is not to deny the potential biological basis of borderline, but rather to cast a critical eye on the sociopolitical dimensions that might influence the researchers, study design, and the scientific enterprise more broadly. Provided the historical and social dimensions of borderline we have reviewed, as well as the compelling literature on the social and political dimension of science itself, a pragmatic ascription of borderline that invokes correlation data must be made cautiously.

In addition to remaining cognizant of the historical legacy of borderline, another cautious tack would entail recognizing that the constellations of behaviors that make up borderline represent a set of irreducible and complex interactions between social and biological factors, which are constantly in flux. This should not come as a surprise nor do I believe it to be a radically groundbreaking insight; many mental illnesses emerge from the nexus of social expectations and biological bases of behaviors. What is unique in our pragmatic analysis of borderline is the way in which we can apply feminist methodology to reveal this disorder's social, political and ethical dimensions before deciding how best to recast those behaviors as disordered or not. For a pragmatic reconstruction of borderline to meet ethical muster, we must acknowledge ideological presuppositions and potential biases and seek to minimize their influence on the reconstruction of the category.

Stigma

In addition to the conceptual feedback loop caused by correlation data, there exist other amplifiers of the standard construction caused by the diagnostic habits and misunderstandings of individual clinicians. Stigma is one such amplifier. According to Goffman, stigma is defined as a physical or social attribute that diminishes a person's social identity and disqualifies her full social acceptance.[43] Stigma represents the differentiation of normal and abnormal, in-group and out-group, and imputes, by definition, a negative view of those who are stigmatized. In presenting his theory of stigma, sociologist Erving Goffman states:

> The attitudes we normal's have toward a person with a stigma, and the actions we take in regard to him, are well known, since these responses are what benevolent social action is designed to soften and ameliorate. By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances. We construct a stigma-theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalizing an animosity based on other differences.[44]

Stigma is, of course, associated with most mental illnesses. But the kind of stigma experienced by patients with personality disorders may have a unique impact, because it exacerbates the very behaviors that generate the stigma. It is now well known that a diagnosis of borderline represents a 'red flag' in the patient's medical history, warning other clinicians and future therapists of the patient's troubled past and potential

therapeutic challenges. A study by Aviram, et al. shows that therapists react more negatively to cases in which a prior diagnosis of borderline had been made.[45] In the case of borderline, the term 'borderline' has shifted back into metaphoric usage, to single out the prototype of the difficult, incorrigibly disturbed (often female) patient. Goffman describes this dimension of stigma stating, "We use stigma terms such as cripple, bastard, moron in our daily discourse as a source of metaphor and imagery, typically without giving thought to the original meaning."[46] The influence of the metaphorical and stereotypical portrayals of the borderline patient, in combination with the actual behaviors of the patient, will oftentimes cause a therapist to recoil. As Aviram, et al. have found, such a response may worsen the patient's condition by exacerbating the stigma and alienation that the patient experiences.

Additionally, as is the case with most stigmatized people, patients with borderline disorder may initiate strategies of "stigma management" to minimize the negative effects of stigma to compensate for or camouflage their abnormality. Management strategies might include behaviors that the clinician interprets as disingenuous, manipulative, or as evidence of an identity disturbance. In a frantic effort to minimize her stigmatized image, the borderline patient redoubles her coping strategies by employing the same dysfunctional behaviors that were the kernel of the problem. Aviram, et al. summarizes the cycle of stigma according to four stages: borderline behaviors of self-injury and withdrawal, the confirmation of stigma, the therapist's emotional distancing, which leads then to further self-loathing, which results in more behavioral dysregulation.[47]

Insights related to the negative impact of stigma created by the diagnosis of borderline might be construed as part of the argument for its demedicalization or

dropping the disorder entirely from the official nosology. It would be a mistake however to interpret these troubling findings about stigma as the final word on the pragmatic ascription of disorder to borderline. As I will now discuss, stigma is a manageable side effect in the otherwise appropriate treatment of borderline as a medical disorder and can be mitigated if in our reconstruction of the category we are cognizant of the stereotypes of borderline. For example, one place to minimize the effects of stigma would be among clinical professionals themselves. Providing them with educational information about newer, more effective therapies and by cultivating several of the aforementioned virtues that aim to provide clinicians an array of intra and interpersonal resources should help them more constructively work with persons who have borderline disorder. Let us now turn to my proposed way to reconstruct the borderline disorder.

Conclusion

In this chapter, I tried to do several things, all aimed at applying key facets of my proposed ethical pragmatic theory of disorder to borderline. First, I provided the reader with historical background on borderline to help ascertain the disorder's problematic past. I have argued the historical construction of borderline has failed to meet the ethical standards I set out for an appropriate pragmatic ascription of disorder. Thus, the standard construction of borderline serves as an anti-paradigm of how the pragmatic theory should be applied. Specifically, the standard construction, as it has been illustrated and amplified throughout its history and in popular portrayals is an instantiation of socio-political oppressive and gendered norms that have inappropriately been applied to various behaviors clustered within the concept of 'borderline.' These norms, in turn, are deeply

rooted in the central constructs of liberal philosophy. Let us now apply these insights as we begin an ethical-pragmatic reconstruction of the classification, diagnosis, and treatment dimensions of borderline personality disorder.

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1. Janet Wirth-Cauchon, *Women and Borderline Personality Disorder: Symptoms and Stories* (New Brunswick: Rutgers University Press, 2001).; Nancy Potter, *Mapping the Edges and the In-between: A Critical Analysis of Borderline Personality Disorder* (New York: Oxford University Press, 2009).

2. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed., text rev. (Arlington, VA: American Psychiatric Publishing, Inc.) "Diagnostic criteria for 301.83 Borderline Personality Disorder: A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following: (1) frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5; (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation; (3) identity disturbance: markedly and persistently unstable self-image or sense of self; (4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5; (5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior; (6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days); (7) chronic feelings of emptiness; (8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights); (9) transient, stress-related paranoid ideation or severe dissociative symptoms."(10.1176.appi.books.9780890423349.3831)

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4. Wirth-Cauchon, 2001, 41; Andrew Wynter, *The Borderlands of Insanity and Other Allied Papers* (New York: G. P. Putnam's Sons, 1875).

5. James Cowles Prichard, *A Treatise on Insanity and Other Disorders Affecting the Mind* (Philadelphia, PA: E.L. Carey & A. Hart, 1837).

6. Wirth-Cauchon, 2001, 3; Adolf Stern, "Transference in Borderline Neuroses," *Psychoanalytic Quarterly* 17, no. 4 (1948):527-528.

7. John G. Gunderson, "Borderline Personality Disorder: Ontogeny of a Diagnosis," *American Journal of Psychiatry* 166, no.5 (2009):530-539.

8. Otto Kernberg, *Borderline Conditions and Pathological Narcissism* (New York: Jason Aronson, 1975), 13.

9. Otto Kernberg, *Borderline Conditions and Pathological Narcissism,* (New York: J. Aronson, 1965), 14.

10. Ibid., 15.

11. Ibid., 61.

12. Gerald Klerman, "Historical Perspectives on Contemporary Schools of Psychopathology," in *Contemporary Directions in Psychopathology: Toward the DSM-IV* ed. Theodore Millon and Gerald L. Klerman (New York: Guilford Press, 1986) 3-28; A complementary account of the evolution of the DSM-III comes by way of Nassir Ghaemi who argues that Karl Jaspers's critical work on Kraepelin had an equally important impact on the manual. Though Jaspers was critical of Kraepelin's reductionism, he agreed that a nosological structure was needed for psychiatry, and that this structure should recognize the complexity of psychiatric conditions. Jaspers likened psycho-nosology to botony—where it was quite easy to describe the characteristics of individual species of plants, but much more difficult to describe the concept of 'plant' itself. Thus, as Ghaemi suggests, Jaspers is "taking a stance here on the old philosophical debate about the particular versus the universal, and saying we should stick with the particular." Indeed,

Jaspers presents a very pragmatic perspective in that he argues that psychiatric nosology is necessary for grounding clinical interactions, treatment, and research. Jaspers even offered his own nosological breakdown, which seems to be reflected in the DSM and ICD that included three groups: Group I, 'Known somatic illnesses with psychic disturbances' (such as cerebral tumors, meningitis); Group II, 'The three major psychoses' ('genuine epilepsy', schizophrenia, and manic-depressive illness); Group III is the 'Personality disorders'. See: S. Nassir Ghaemi, "Nosologomania: DSM & Karl Jaspers' Critique of Kraepelin," *Philosophy, Ethics, and Humanities in Medicine* 4, no. 10 (2009) doi:10.1186/1747-5341-4-10.

13. Eli Robins and Samuel B. Guze, "Establishment of Diagnostic Validity in Psychiatric Illness: Its Application to Schizophrenia," *American Journal of Psychiatry* 126 (1970): 983-987.

14. Laura S. Brown, "A Feminist Critique of the Personality Disorders," in *Personality and Psychopathology: Feminist Reappraisals*, ed. Laura S. Brown and Mary Ballou (New York: Guilford Press, 1992), 210.

15. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders,* 3rd ed.(Washington, DC, American Psychiatric Association, 1980).

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18. Marcie Kaplan, 1983. "A Woman's View of DSM-III," *American Psychologist* 38, no. 7(1983): 788-789.

19. Phyllis Rooney, "Gendered Reason: Sex Metaphor and Conceptions of Reason," *Hypatia* 6, no. 2 (1991): 86.

20. Wirth-Cauchon, 2001, 43.

21. Martin Leichtman, "Evolving Concepts of Borderline Personality Disorders." *Bulletin of the Menninger Clinic* 53, no. 3 (1989): 230.

22. Christine Ann Lawson, *Understanding the Borderline Mother: Helping Her Children Transcend the Intense, Unpredictable, and Volatile Relationship* (New York: Rowman & Littlefield Publishers, Inc, 2002), 5.

23. Ibid., 30.

24. Ibid., 142-143.

25. Ibid., 37-38.

26. Rooney, 1991, 91.

27. For example, Wirth-Cauchon cites the work of Danny Wedding and Mary Ann Boyd, whose book, *Movies and Mental Illness* (1998), includes a case work-up of Alex Forrest (played by Glenn Close in *Fatal Attraction*). Wirth-Cauchon argues both that the portrayal of borderline is deeply flawed and, importantly, any lessons gleaned from this portrayal will overlook the basic context within which borderline instantiates in the real world. To Wirth-Cauchon such representations ignore the most important features of women's experience of borderline and its underlying causes. Moreover, the portrayal of Forrest as a 'madwoman' and Dan Gallagher (played by Michael Douglas) as the innocent victim reinforces the legitimacy of a patriarchal power relation.

28. Joel Anderson and Axel Honneth, "Autonomy, Vulnerability, Recognition, and Justice" *Autonomy and the Challenges to Liberalism New Essays* ed. John Christman and Joel Anderson (New York: Cambridge University Press, 2005), 128, italics in original.

29. For example, the distinction between procedural autonomy and substantive autonomy is one attempt to retain a concept of the rational self, while recognizing the effect oppression has on rational decision making. See Catriona Mackenzie and Natalie Stoljar, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford: Oxford University Press, 2000).

30. John F. Clarkin, Mark F. Lenzenweger, Frank Yeomans, Kenneth N. Levy, and Otto Kernberg, "An Object Relations Model of Borderline Pathology." *Journal of Personality Disorders* 21, no. 5(2007): 476.

31. Jay R. Greenberg, Stephen A. Mitchell, *Object Relations in Psychoanalytic Theory* (Cambridge, MA: Harvard University Press, 1983), 12.

32. Ibid, 477, italics mine.

33. Dana Becker, *Through the Looking Glass: Women and Borderline Personality Disorder* (Boulder, CO: Westview Press, 1997), 51-52.

34. Otto Kernberg, *Borderline Conditions and Pathological Narcissism* (New York: Jason Aronson, 1974), 71.

35. Clarkin, et al., 2007, 483.

36. Drew Westen and Jonathan Shedler, "Revising and Assessing Axis II, Part II: Toward an Empirically Based and Clinically Useful Classification of Personality Disorders." *American Journal of Psychiatry* 156 (1999): 273–285.

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40. José De la Fuente, Serge Goldman, Etienne Stanus, Coro Vizuete, Ignacio Morlán, Julio Bobes, and Julien Mendlewicz, "Brain Glucose Metabolism in Borderline Personality Disorder," *Journal of Psychiatric Research* 31, no. 5(1997): 531-541; Heather A. Berlin, Edmund T. Rolls, Susan D. Iversen, "Borderline Personality Disorder, Impulsivity, and the Orbitofrontal Cortex," *American Journal of Psychiatry* 162, (2005): 2360–2373.

41. Milagros Evardone, Gerianne M. Alexander, and Leslie C. Morey, "Hormones and Borderline Personality Features," *Personality and Individual Differences* 44, no. 1(2007): 285.

42. Marijn A. Distel, Irene Rebollo-Mesa, Gonneke Willemsen, Catherine A. Derom, Timothy J. Trull, Nicholas G. Martin, Dorret I. Boomsma, "Familial Resemblance of Borderline Personality Disorder Features: Genetic or Cultural Transmission?" *PLoS ONE* 4, no. 4(2009): e5334. doi:10.1371/journal.pone.0005334; Despite their widespread use, twin study methods have been criticized as unreliable because they provide no real environmental controls. See: Jay Joseph, "Twin Studies in Psychiatry and Psychology: Science or Pseudoscience." *Psychiatric Quarterly* 73 no.1 (2002): 71-82.

43. Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity* (New York: Simon and Schuster, 1963)

44. Ibid, 5.

45. Ron B. Aviram, Beth S. Brodsky, and Barbara Stanley, "Borderline Personality Disorder, Stigma, and Treatment Implications," *Harvard Review of Psychiatry* 4, no. 5(2006): 249-256. The reasons for this negative reaction are yet to be determined. One plausible explanation is that clinicians assume personality disorders and borderline particularly are not mental disorders. Rather, they are personal failings and problematic behaviors are not instances of symptoms but rather as "the patient's choice to make an interpersonal demand upon the clinician," (250).

46. Goffman, 1963, 5.

47. Aviram, et al, 2006, 252.

CHAPTER 7

AN ETHICAL-PRAGMATIC RECONSTRUCTION OF BORDERLINE PERSONALITY DISORDER (PART II)

Introduction

To reconstruct borderline personality disorder according to our pragmatic theory will require conceptual adjustments and ethical considerations be applied at each of the key junctures of disorder-ascription that I described in chapter 5 alongside insights from the critical analysis presented in chapter 6. Therefore, in this chapter, I will consider four ways to refocus psychiatric and philosophical attention on borderline in a pragmatic effort to offer a more ethically justifiable method to both classify and diagnose constellations of behavior as disordered. This will in turn have a positive impact on the efficacy of therapies designed to relieve the suffering experienced by borderline patients and of those with whom she interacts.

First, in order to clarify and recognize the context of the suffering experienced by those affected by borderline in a way that satisfies the proposed pragmatic-ethical benchmarks, I will consider broad proposals to restructure the classification itself. One possibility is to completely re-categorize borderline by interpreting its characteristic socially dysfunctional behaviors as instances of manic impulsivity. Indeed, some have suggested that subsuming the disorder under the larger spectra of bipolar or post-traumatic stress disorders will help to minimize the disorder's stigma and will facilitate more efficacious kinds of therapeutic intervention. This is certainly one very attractive pragmatic option that I will consider in some detail as I ask whether or not such a

proposal fulfills the basic ethical principle of authentic beneficence (i.e. for whom would such a reclassification primarily benefit: the patient, the clinician or the researcher?).

Second, I will describe how to recast symptoms in order to filter out biases that seem to be latent in the way in which borderline behaviors are viewed and labeled. This move is related, of course, to the first consideration, but will be more of a specific treatment of particular symptoms of borderline. As I alluded to in the previous chapter, a reconsideration of symptoms such as anger and manipulation through a more contextual lens is an essential part of what I take to be an ethically justifiable pragmatic reconstruction. I will therefore take time in this chapter to argue for an epistemic shift in how we interpret specific habits that constitute the characteristic behavioral constellation of borderline. In doing so, I hope to show that the benefits of adjusting our comprehension of specific symptoms will pay dividends in therapeutic efficacy, which brings me to the third goal of this chapter.

I propose rethinking standard treatment modalities to recognize the historical and ideological biases that have for so long hindered the development of efficacious treatment programs. To this end, the use and development of feminist and dialectal behavioral therapies have been promising. Moreover, a key will be to develop therapeutic strategies that help the borderline patient understand their anger is legitimate but misdirected. This is to say, in the spirit of dialectical therapy, the pragmatic step will be to essentially coach borderline patients to realign the focus of their anger toward constructive goals like political activism. Psychoeducation with borderline patients is crucial to help them distinguish between legitimate targets of anger—such as oppressive social structures and

people who support such structures—and other people who authentically desire to help the patient with her difficulties.

Fourth, I will consider explicitly ways to recognize the far-reaching effects of borderline on persons other than the patient. Drawing on ideas from systems therapy, I will describe ways to protect the health and welfare of friends and family who try to help those with the disorder and who are either directly hurt or suffer from collateral damage caused by the disordered person. In this last section, I offer thoughts on how to best treat borderline while also keeping in mind the public health model of mental disorder, and also considering controversial dimensions of that model (such as the possibility that it would be coercive). Let us now look at each of these proposals in turn.

Reconsidering Classification

I hope I have provided enough background to show that the way in which the borderline disorder has been historically constructed and metaphorically framed is ethically problematic. We saw that both historical and narrative constructions of borderline betray certain gender biases. Likewise, in some respects, psychometric and neurological research tends to question-beg in the way borderline behaviors are defined and assessed. In combination with the stigma-cycle, the standard construction of borderline has a self-sustaining oppressive effect. Ultimately, biased diagnostic criteria single out behaviors that deviate from the social norm, while simultaneously reinforcing the oppressive structures that originally defined that norm. As I mentioned, some will argue that the above critical analysis supports the claim that borderline is a social artifact produced by oppression and, consequently, what needs to be fixed are the structures that

create the context of the disorder. In other words, borderline disorder is not really a 'disorder', but, rather, it is an understandable set of responses and defensive behaviors exhibited by those who are victimized by oppressive social structures.

Indeed, I fully acknowledge this point. It is not surprising that oppressive social structures influence and stimulate compensatory behaviors by those in oppressed groups, and that some of these behaviors can turn out to be problematic to both the oppressor and the victim. In the case of borderline this seems to be the case as the criteria and etiological evidence related to the disorder directly correspond to what Iris Young has called the five faces of oppression.[1] Specifically, the fear of violence, systemic economic exploitation, and a sense of powerlessness all seem to predispose a woman to the borderline disorder. Such structures often demand various borderline behaviors for survival. Oppressive structures therefore might serve as incubators within which precocious borderline women are formed. It therefore seems accurate to recognize borderline behaviors among women as representing the sequelae of psychological injury to the female psyche caused by oppressive social structures. In addition, it is the case that a direct connection between abuse and borderline has been established. Such abuse might come in the form of physical violence by a parent, psychological threats, or a generally toxic ambience within the family structure. Prolonged exposure to such psychological insults will inevitably lead to some form of trauma and in many causes with chronic stress. Indeed, recent data indicate borderline has about 30% comorbidity with PTSD.

With this in mind, I wish to point out a direction forward for reframing the classification and understanding of borderline through Laura Brown's concept of "Abuse and Oppression Artifact" disorders. Brown proposes differentiating personality disorders

to include "careful investigation of competing hypotheses such as gender-role socialization, abuse experiences, and cultural oppression prior to consideration of a diagnosis of personality disorder."[2] Her theory encompasses the social context of borderline behavior, paying particular attention to the patient's history of abuse and sexist social structures that create chronic stress. Similarly, as I will describe, feminist models of psychotherapy attempt to integrate clear recognition of social and political position in diagnosing and treating the borderline woman. Although the historical construction of the disorder, recent tropes, and empirical research continue to problematize the borderline disorder according to a gendered ideal of the self, these more recent trends toward contextual treatment and understanding of the disorder are promising. This is one promising avenue for the conceptual reexamination of borderline.

Another possibility would be to reclassify borderline in terms of another mental disorder. Some researchers have suggested considering borderline to be part of the bipolar disorder spectrum. Noticing that bipolar and borderline are very often comorbid conditions, and that many of the affect disturbances are common in both syndromes, Smith, et al. have suggest that there is a strong case to be made for subsuming a significant number of borderline patients under the rubric of bipolar disease.[3] The authors articulate several pragmatic reasons for this move. One such reason reflects the fact that the standard construction of borderline is difficult to treat because of transference and countertransference. Inadvertent countertransference can be especially fraught because it leads to an overreliance on treatment strategies such as pharmacotherapy, which, as Valliant states, "if pursued too enthusiastically are more likely to lead to disaster than to success."[4]

Smith, et al. note that by reframing the difficult-to-treat behaviors as instances of bipolar symptoms, clinicians will more easily treat patients without falling prey to instances of countertransference. Moreover, they claim, such a redefinition of borderline will spare the patient of the stigma of a 'character disorder' and replace it with a much more manageable stigma of bipolar disease, which is more widely accepted as a true mental illness. In sum, Smith, et al. suggest,

> A reframing of borderline patients as suffering from a primary disorder of mood is likely to hold potential benefits for patient and clinician alike. It should reduce stigma and discrimination for patients, who can see themselves as suffering from a valid psychiatric disorder instead of being some way "flawed in character." Similarly, clinicians can approach these patients from new angles and apply treatment skills, both pharmacological and psychological, already gained in the treatment of mood disorders. Ultimately the hope is that such an approach would reduce the risk of therapeutic nihilism in the care of this important and highly morbid group of patients.[5]

This is indeed an attractive pragmatic solution to the problems associated with treating borderline patients. But one must ask, would such a pragmatic revision meet the ethical guidelines I have suggested? Is this pragmatic re-ascription rooted in a set of reasonably sound ethical considerations? Is such a move motivated primarily for the benefit of patients or for clinicians who have trouble mastering complicated treatment techniques for borderlines?

Although it seems the authors wish to frame this move as a win-win for patients and clinicians, it seems shortsighted in the way it simply uses a relabeling to avoid more fundamental problems associated with the way in which the constellation of behaviors are singled out. This is to say, what is more important in reconstructing borderline is figuring out *why* we label borderline behaviors dysfunctional in the first place. The proposed pragmatic move only reinforces the unspoken biases related to borderline disorder and may in fact exacerbate these biases by forcing them deeper underground, masked under the well established rubric of bipolar disorder. It is also curious that the authors think this strategy will reduce the risk of therapeutic nihilism—or the tendency of clinicians to believe nothing can be done for the patients. In a sense, the authors are calling for a relabeling of borderline to trick clinicians out of their latent biases about borderlines, instead of tackling the roots of those biases head on. I am thus dubious about this strategy for philosophical reasons.

Others are skeptical as well. Psychiatrist Joel Paris argues that what Smith, et al. suggest has no basis in psychological evidence. Borderline represents a distinct form of disorder from bipolar—it is distinct in its etiology, phenomenology, and longitudinal course, heritability, and treatment. Simply because there are similar symptoms across bipolar and borderline does not justify coalescing the two categories. Paris points out that, "in medicine, similar symptoms can have entirely different causes. Clinical symptoms that resemble the mood changes seen in bipolar disorder may be no more specific than fever or inflammation."[6] Thus, Smith, et al.'s proposal runs the risk of overlooking critically important dimensions of borderline while it also discourages

research into borderline's complex etiology, an examination of social and political structures that may serve as incubators of the disorder, and of possible therapies.

Suffice it to say, reframing the category of borderline requires a critical analysis of the oppressive factors that seem to play a role in the etiology of the disorder. According to the ethical guideposts I set out in the chapter 5, the pragmatic theory requires that the broader social forces that influence the category be factored explicitly into the ascription or construction of the disorder. In contrast to Smith, et al., Brown offers a more promising strategy for doing both. With Brown, the primary motivation is to understand the classification of the disorder in a way that prioritizes the patient's experience, emphasizes clinician insight and uptake, and relies on trustworthiness and beneficence. Thus, Brown's strategy begins to satisfy our ethical considerations. The strategy offered by Smith et al. seems to be ethically deficient both in its questionable motivation and because of doubts about whether it would actually work. Let us turn now to see how Brown's proposal might play out in the context of the symptoms of manipulation and impulsivity.

Recasting Symptoms: Manipulation & Impulsivity

As we now know, closely associated with the above discussion about diagnostic reconceptualization, is another important set of ethical-pragmatic steps toward reconstructing borderline according our theory. These steps entail making an epistemic shift in the way we come to know and understand each of the specific habits that constitute the behavioral constellation of concern. In contrast to more acute symptoms of borderline (suicidal behavior, self mutilation), several symptoms have been described by Zanarini, et al. as "temperamental symptoms."[7] These tend to resolve slowly with

therapy, if at all. Among the temperamental symptoms there are several that are candidates for reappraisal according to a new ethical-pragmatic critical analysis. For example, a more robust contextual examination is needed when considering the symptomatic features of anger and manipulation, which we know marked features of the borderline patient. As Nancy Potter suggests, the claim that the borderline woman is manipulative relies on a particular assumption about the freedom, opportunity, and the classical concepts of autonomy and the ideal self, which I described above. She suggests the clinical observation that a borderline woman is manipulative often ignores the context, out of which such behavior is necessary:

> When someone aches for relationship and connection but characteristically behaves in ways that prevent that person from sustaining them, the behavior is dysfunctional with respect to a vital human need. But I can also imagine a defense of behavior that is manipulative, for direct access to power and voice are not equally available to all of us, and manipulation may be a survival skill.[8]

In such cases, lying and deceit may be an unfortunate learned response that is the byproduct of abuse, neglect, or ambient oppression. Perhaps such behavior is an acute defensive reaction to yet another asymmetrical power structure—the therapist-patient dyad—of which the borderline woman is now a (lesser) part. By recasting the symptoms of anger and manipulation in this critical way, we may advance our reconstruction of borderline and avoid the temptation to simply 'classify away' evidence of deeper social and political injustices.

The symptoms included within the rubric of 'impulsivity' provide another

interesting case study whereby negative meaning is attached to behaviors that are haphazardly construed as irrational, dysfunctional and self-destructive. As a category of symptoms, 'impulsivity' is a blunt instrument used to describe a wide array of behaviors among borderlines from drug and alcohol use to shopping to sexual behavior. One way in which this symptom category seems to be problematic is that it robs patients of freedom to live with any amount of spontaneity lest they be judged as impulsive and irrational. Thus, to more carefully refine how behaviors considered to be impulsive are understood, it is first important to try to distinguish between spontaneous behaviors and impulsive ones. One way to distinguish the two would be to understand the value associated with each kind of behavior; Potter explains why and how impulsive behaviors are considered negative while spontaneous behaviors are thought to be good.

Employing insights from Lee Brown, Potter illustrates the goodness of spontaneity using the example of jazz music. The jazz musician produces music through improvisation; but this improvisation is part of a larger meaning of the musical genre itself. Moreover, the jazz musician is "self-monitoring", meaning he is gifted with the intuition and insight to know how to produce in the right time the sounds that make the improvisation successful and pleasing to listeners. This is to say the jazz musician, although improvising from moment to moment, "does so through deliberation and action [that is] situated within larger plans and aims."[9] Potter distinguishes this from those who act impulsively using the 'Olaf Principle', a term coined by Lynne McFall, which refers to the character of a poem by e.e. cummings who resists succumbing to physical torture as a contentious objector. The key point of the Olaf Principle is that there are certain commitments in our lives that we would be willing to part with and that are less

important to us than other things. However, there are other things that are much more important to us; they are 'identity-conferring' or higher order commitments. These commitments define one's sense of self and should be indefeasible. Impulsive individuals however, uncontrollably compromise these commitments, which results in shame as well as in further erosion of the person's sense of self. Both shame and the erosions of one's sense of self ultimately cause more profound suffering and distress.

The symptom of impulsivity is especially germane when discussing women's sexuality vis-à-vis borderline. As Potter suggests, the rote application of the concept of impulsivity to women's sexual behavior belies gendered expectations—that a woman who engages in casual sex is impulsive, slutty, or whorish. Potter explains that such behavior needs to be understood in terms of the Olaf Principle by asking, "Are these women violating their own higher order standards of behavior and integrity and, if so, why?"

Potter admits one risk in this kind of analysis is that it shifts us back into the debate about whether the behaviors are signs of mental illness or vice—which I argued in chapter 4 is an impractical and ultimately unproductive debate. This juncture of the case analysis provides an opportunity to both reiterate and strengthen the pragmatic argument, by using borderline impulsivity as an example of how difficult it can be to clearly parse the behaviors in terms of the distinction between 'mad' and 'bad.' In other words, the attempt to try to figure out the *true* nature of impulsivity—that is, whether or not impulses are in some way volitional and thus less deserving of the ascription 'disorder'—is somewhat of a red herring, at least from a pragmatic perspective. It distracts us from the ethical-pragmatic motivation of relieving suffering, which I have argued should

remain primary to how we understand socially dysfunctional behaviors. Therefore, in the case of impulsivity, the question of volition *vis-à-vis* impulsivity should be secondary to the question of minimizing the harm caused by such impulsivity. It might turn out that appealing to the borderline patient's sense of free will, particularly if she can be shown that such behaviors ultimately damage or diminish her freedom and life's options, might help her to control impulsive behaviors. If appealing to a patient's free will turns out to be helpful, then treating impulsivity *as if it were volitional* is the pragmatically justifiable strategy. If, on the other hand, impulsive symptoms seem to be more effectively managed by treating them *as if they are caused by a brain-based disorder*, then appealing to the medical disorder as the cause is more justifiable. Thus what I am proposing is that the 'mad' vs. 'bad' distinction be used in whatever way possible to minimize the suffering cause by borderline impulsivity, regardless of the true nature of that impulsivity.

In addition to this pragmatic reappraisal of the mad v. bad debate with relation to impulsivity, I have one final concern with the Olaf Principle, which I should briefly mention. It seems to me is that it is very difficult to disentangle the individual's genuine wishes (or first order commitments) from social expectations about what those commitments ideally should be. This confusion may lead to questions about validity and authenticity of the commitments described by the Olaf principle. Thus, we are back to the original problem of wondering whether or not symptoms, such as impulsivity, are reflections more of social expectations than of individual choice.

Nonetheless, despite these limitations, I think that recasting the symptom of impulsivity against the contextual background proposed by Potter is an important step

forward in our ethical-pragmatic reconstruction of borderline, because it helps to promote a concept of impulsivity that is not dependent on potentially sexist expectations. Let us now discuss how treatments might be reimagined to more adequately and ethically meet our goal of minimizing the suffering caused by borderline personality disorder.

Rethinking Treatment: Dialectical Therapy & Uptake

Since the 1960's there have been a plethora of published accounts detailing the challenges often encountered when treating patients with borderline. Through personal narratives, case studies and empirical research, therapists time and again have described difficulties in their attempts to significantly alter the pervasively dysfunctional habits of borderline patients. As Gunderson notes, pejorative descriptors such as "frequent flyer," "help-rejecting complainers," "egocentric," and "irresponsible" are generously sprinkled throughout the literature and clinical lexicon. One researcher referred to borderline patients as "intractable, unruly" patients who used hospitals to escape from responsibilities.[10] Gunderson has articulated the key treatment dilemmas that are encountered in treating borderline patients. These include:

- Dramatic fluctuations in phenomenology and psychological capacities will challenge diagnostic certainty.
- Urgent appeals for an exclusive helping relationship will generate strong countertransference responses, often involving rescue efforts that prove to be inadequate.
- Treaters and others will have intense and distinct reactions, seeing the patient as a deprived waif or as an angry bully.

- Separation experiences (or decreased structure) will prompt behavioral (self-harm) and cognitive (psychotic-like) regressions.
- Neither psychoanalysis nor medication will help significantly and will often be harmful.[11]

As described above, such therapeutic difficulties seem to be impervious to conventional modalities. And over the past two decades, it has become clear that conventional treatments such as cognitive behavioral therapy (CBT) or psychoanalysis seemed to fall flat (or, worse, exacerbate symptoms) when dealing with the borderline disorder. CBT seemed both theoretically and pragmatically ill-suited to critically examine the milieu of oppression, empathically explore histories of abuse, and constructively prescribe action plans for borderline patients. What was needed was a shift in the orientation of CBT to more aptly address the issues that left borderline patients languishing in a treatment program built on a form of prescriptive rational thinking that further alienated borderlines.

Marsha Linehan's dialectical behavioral therapy (DBT) has sought to overhaul the standard CBT model by augmenting it with features that enable the therapist to address these more complex symptoms of the borderline patient.[12] The methods of DBT depart from conventional CBT in its shift away from overt change-oriented interventions to acceptance and validation interventions. The dialectical relationship between acceptance and change creates a stronger, more constructive relationship between the client and therapist, which provides the needed foundation for long-term work. The key aspect of DBT is strategic acceptance and validation of the concerns of borderline patients—which had so often been discounted and marginalized as the ravings of a hysteric. Thus, DBT

provides a structure for the concepts of uptake that and world travel described in the chapter 5.

Indeed, DBT's emphasis on acceptance and validation is reflective of the feminist intuition, which is the claim that norms of femininity influence expectations and enhance the oppression, making critical decisions women make "nonautonomous."[13] Feminist therapeutic approaches are well-equipped to provide the critical perspective and systems-based approach to therapy. These approaches are varied and diverse, much like their philosophical counterparts, and range from liberal feminist techniques, which aim toward individual actualization and self fulfillment, to radical feminist therapy that emphasizes the therapeutic potential (and moral calling) of political activism. They appeal to the feminist consciousness, which is defined as the "awareness that one's own suffering arises not from individual deficits but rather from the ways in which one has been systemically invalidated, excluded, and silenced because of one's status as a member of a nondominant group in the culture."[14]

All of these approaches share the common features that dovetail with our pragmatic ethical approach to both ascribing and treating the borderline disorder. They recognize that personal "issues" are in part reflections of political realities. They demand therapists have a deeper understanding of the oppressive socio-political factors that may have caused or continue to enhance the disorder. Feminist methods of therapy for trauma victims also meet these treatment standards. For example, Laura Brown proposes several important features of feminist therapeutic techniques for treating trauma. Key features such as recognition that the client should not simply be 'healed' but also empowered to recognize and work to change the forces of marginalization, oppression, and abuse: "it is

insufficient to treat one client and return that person to a world in which her or his trauma will continue to occur unchecked."[15]

Linking up the pragmatic theory of disorder with new, more effective treatments of borderline disorder—through a recognition of the subjective experiences of the client, the unique social contexts, and, importantly, the limits of conventional therapy—should help clinicians cultivate therapeutic insight to more ably provide uptake and subsequent relief to suffering clients. This is resonated by Potter, who encourages clinicians toward 'epistemic humility' and understands that:

> ...clinicians can, and should, think critically about ways in which prevailing norms and values may be influencing their understanding of the world and their ways of being in it. They need to be on guard against subtle assumptions about health, rationality, and good actions that could be misguided in the case of a particular patient and thereby inhibit that patient's ability to heal."[16]

These are just a few insights related to new forms of treatment that might support a reconstructed version of borderline. Let us take a very brief look at one final set of methods that recognizes the impact of borderline on families, friends, and the larger community.

Recognizing Public Health Risks: Systems Therapies

Recall one constitutive element of the pragmatic version of a personality disorder was recognizing its negative impact on others. As I described in Chapter 4, the public health model can be aptly applied to borderline disorder not as a direct analogy but as a heuristic that offers guidance on how to structure and deploy systematic interventions for

the good of the broader community. The value of such an approach is recognized in cases of antisocial personality disorder or psychopathy. Social structures that aim to protect the community from the damage of persons with such disorders are ubiquitous—from legal protections and the criminal justice system to less formal personality assessment regimes that seek to weed out troubled individuals from the ranks of employees, the armed services, the clergy, etc. The very legitimate concerns about the effectiveness or ethical legitimacy of these structures are afield from my main point here, which is simply to say that the importance of public health interventions for serious mental disorders seems reasonable. In the case of borderline, as I had mentioned its public health dimensions remain largely unexplored, despite evidence that it has far reaching implications on families, places of employment, and the community more generally. Therefore, in our reconstruction of the disorder, these insights must be more carefully examined, keeping in mind, again the latent power structures that might illegitimately signify borderline as aberrant.

In any case, as with refinements to its classification, methods to treat borderline disorder ought to also address its impact on the larger community. There are several therapeutic options to mitigate the impact of borderline on nonpatients. One such strategy, group skills training, is integrated into DBT. Surprisingly, there is very little research into specific systems therapies (family therapy) for borderline patients and their families. As Hoffman, et al. explain, there are now several family therapy methods developed specifically to treat the impact of a particular disorder suffered by one or more members of the family.[17] Methods of family therapy for anorexia nervosa, bipolar disorder, schizophrenia, and addiction are now widely available. Successful strategies

include meetings of multiple families, bringing together large groups of people who are adversely affected by the mental illness of family members. But, despite a growing number of patients with borderline, no such systematic strategies currently exist for them or their families.

A few models do exist that seem promising. The first is Dialectical Behavior Therapy-Family Skills Training (DBT-FST) with or without multiple families as described by Hoffman, et al. The first key element of DBT-FST is psychoeducation, which entails providing family members the background to help them understand the clinical dimensions of the troubling behaviors of their family member. The second goal is to teach family members a new, less confrontational vocabulary with which to communicate about problem behaviors. The third goal is to teach both patients and family members to be less judgmental of one another by accepting the central tenet of DBT—that there is no 'absolute' truth. Finally, the fourth goal, which seems prior to the other three, is to provide the family a safe place to discuss extraordinarily difficult issues openly.

Assertive community therapy (ACT) is an approach that provides the severely mentally ill with individualized treatment and rehabilitation regimes that aim specifically toward providing patients with the stability to live independently and become (and stay) employed. Although costly, studies indicate that programs of ACT (PACT) are cost-effective, reducing the duration of in-patient hospitalization.[18] One PACT client has described his experience in the following way:

> One of the good features of PACT is that people have ongoing care that provides stability and continuity in their lives. And the care provided by

> the staff can mean a break and a relief for the family; no longer do families have to be the treaters. Instead they can live their lives knowing their loved one is being treated, and that eases the stress and strain on families. For the most part, families are a part of the treatment team at PACT. They are listened to and are respected by the program. This community-based program, in my thinking, is another word for hope. It isn't perfect. But for now, PACT—even after some 25+ years—is still an innovative idea. With time and hard work there will be more PACTs out there with more and more people getting good quality community treatment.[19]

NAMI has endorsed ACT and has stated that one of its goals is "to make high quality ACT teams available to all who need them and to educate others about the effectiveness of this model."[20]

I should mention here that ACT programs are not without controversy. One critic of ACT, Tomi Gomory, channels Szasz in his vigorous challenge of ACT as being both coercive and legitimized by a steady stream of invalid (i.e. tautological) outcomes findings. Using historical evidence from the development of ACT at the Mendota State Hospital in Wisconsin, Gomory argues that the ACT model,

> is innately coercive and rests on a view of mental health patients held by its developers as aggressive, willful actors who use various 'weapons of insanity'... ACT clients are forced by aggressive workers to comply involuntarily with program demands and this activity results tautologically in the misattribution of worker behavior for that of the client (i.e., client is

> forced to show up at an employment site and is 'helped' to stay there, which is then counted as a day spent by the client in voluntary employment for the purpose of ACT validation)... In a coercive climate, forced or imposed client change is passed off as internalized or learned client change.[21]

Additionally, Gormory argues that in most outcomes studies, hospitalization in-take procedures had been modified for patients receiving ACT. Thus, cost-saving estimates are wrong.

Gormory's strong criticism of ACT does not invalidate its potential as a promising intervention in a public health effort to mitigate the ill-effects of borderline personality disorder. But it does remind us of the problems of medical over-involvement especially in cases where the public health hazards are much less clear than cases of disease outbreaks. Nonetheless, demand for family and community based interventions for severe mental illnesses have increased dramatically. In response, organizations like NAMI have developed a variety of programs. For example, NAMI's Family-to-Family program is a 12-week peer-led support class that aims to empower family members of mentally ill persons with psychoeducation and provides them skills to more ably manage the stress of caregiving or the contentious relationship they might have with their mentally ill family member. Qualitative outcomes data seem to indicate that such programs offer a unique benefit by helping family members shift their understanding of mental illness and begin to implement healthier coping skills, enhancing their communication and reducing anger.[22] In the next chapter, I will discuss how such

programs might be integrated into a larger policy framework for patients, family, and other caregivers.

Conclusion

To reconstruct the concept of borderline personality disorder, I argued first in chapter 6 that its historical construction be reconsidered according to the critical theoretical standards I proposed in chapter 5. Similarly, the symptoms of borderline need to be recast so that they are understood contextually, and not simply as isolated incidents akin to hysterical outbursts or in terms of colloquial understandings of manipulation, lying, and impulsivity. I provided a few thumbnails of treatment modalities that seem to meet the standards I have endorsed in my ethical subtheories. These included a shift away from change-oriented therapies like CBT to acceptance and validation oriented therapies such as Linehan's DBT. Supporting this move are the philosophical insights of feminist philosophers and therapists who have developed models of therapy that aim to engender empowerment, meaning and political activism among their clients. To address the reality that borderline presents as a problem for families and the public, I have offered two potential interventions that seem promising. Notwithstanding drawbacks, both DBT-FST and PACT may help to fill the current void of specialized systems therapies for borderline disorder. Such approaches fit into the pragmatic theory because they recognize the adverse affect of the disorder on the broader community, while they also aim to help client-patients establish and maintain stable and productive lives.

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CHAPTER 8

PRAGMATIC ASCRIPTIONS OF MENTAL DISORDER: POLICY CONSIDERATIONS

Introduction

In March 2010, while I was writing this dissertation, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. The PPACA will dramatically alter the state of the U.S. healthcare system in the way patients are covered by insurance providers, in the way health care is delivered, and (hopefully) in the way costs are controlled. In this concluding chapter of my dissertation, I wish to briefly discuss potential areas of intersection between my pragmatic theory of mental disorder and key aspects of health care policy. The goal of this final chapter is relatively modest. First, I will sketch a set of considerations for policymakers, patients, families, and others affected by borderline personality disorder by first offering a brief critical analysis of the current state of the disorder within the domain of public policy. In doing so, I will critique the current political construction of the disorder and discuss ways to democratize the process of diagnostic changes being currently considered for boundary cases.

Next, I will begin to discuss how a pragmatic theory of mental disorder might inform two key questions. The first question concerns the potential need for reasonable accommodations for persons with borderline. Because borderline is such a complex disorder and is defined in terms of social dysfunction, the question of whether and how the Americans with Disabilities Act covers it, for example, is vexing. Admittedly, this is more of a legal question that is outside the scope of this dissertation; however, the pragmatic goals of this dissertation make this a reasonable issue to begin to take up.

The second question concerns improving access and treatment options for borderline patients, their family members, or others secondarily affected by the disorder. I will discuss potentially promising options that are implicitly or explicitly endorsed by PPACA's mental health care parity provisions, including specialty care medical homes. I will not present exhaustive arguments or attempt to conclusively answer these questions. Rather, I present these issues with an eye toward future research. Let us first begin by discussing the place of personality disorders as a funding priority and in health policy more generally.

Political Recognition, Participation, & Shifting Categories

It seems fitting that I began writing this chapter in May, which the National Education Alliance for Borderline Personality Disorder designated as Borderline Personality Disorder Awareness Month. The House of Representatives endorsed this designation in H.R. 1005, which was passed with unanimous support in April 2008.[1] Representative Tom Davis (R-VA), who sponsored the resolution, said, "Mental health professionals have recognized this disease since 1980, yet it continues to lag far behind other psychiatric disorders of similar prevalence in research, treatment options and family education...Raising awareness of this disease is an important first step toward getting the recognition and research dollars that, hopefully, can help future victims and their families avoid the enormous suffering this disease causes now."[2] Co-sponsor, Chris Van Hollen (D-MD), echoed these sentiments, "Though it was officially recognized in 1980 by the psychiatric community, borderline personality disorder is at least two decades behind in research, treatment options, and education compared to other major mental illnesses."[3]

As the DSM-III had created and provided clinicians with an official label for borderline, the House resolution provided the political imprimatur for broader recognition of the disorder, encouraging further research, funding and policy development. This is undoubtedly a good thing. But we must qualify our optimism and from a critical pragmatic perspective we should ask the following questions: what motivated such political recognition? Does such political recognition—as far as we can glean from H.R. 1005 and subsequent policies—support a more ethically justifiable and pragmatically advantageous understanding of borderline? Or does it reinforce flawed assumptions about the disorder? In other words, will the current political recognition of borderline personality disorder help to minimize suffering and reshape clinical efforts to treat the disorder?

The lawmakers' statements and the resolution they helped to craft show that the political construction of borderline relies exclusively on a naturalistic model of the disordered personality. As we saw in Chapter 2, such a definition is biologically based and relies on the belief that personality disorders have been and can be defined in terms of biological dysfunction—this is to say, they are defined in terms of a deviation of species typical biological function. In the case of borderline, it has been argued that this dysfunction is ostensibly at the level of brain morphology and activity. However, we also know that the official schedules of mental illness—the DSM and the ICD—define personality disorders according to deviations from social expectations. Thus the political pronouncements about the status of borderline disorder seem to ignore the current diagnostic consensus that such complex constellations of problematic behaviors are irreducible to discrete biological dysfunctions. The resolution also contains language that

is scientifically dubious and as yet unproven (e.g. "Whereas BPD is inheritable..."). Moreover, as a result of the explicit political endorsement of the biological model for borderline, a dichotomy is set up and strengthened. Patients, clinicians, and family members are left with the false choice, which I have tried to discharge, that borderline patients are either grossly incapacitated or they are blameworthy.

The pervasive use of biological language is also ethically questionable because such language provides tacit endorsement for the disease model espoused by pharmaceutical companies, NAMI and other very powerful stakeholders in the mental health policy arena. Such an endorsement does not necessarily entail that the suggested disease model is unjustifiable. But recall, from the ethical considerations outlined in chapter 5, that for a more ethically justifiable pragmatic ascription of mental disorder we must critically examine the role of powerful stakeholders who motivate and grant these ascriptions. Resonating the aforementioned insights of Herbert Fingarette, Peter Conrad, and other scholars of medicalization, public misunderstandings about the methods and processes of scientific advance are easily exploited by the scientific-industrial enterprise, which pushes for technological solutions for complex social problems.

Such influence, of course, should not be surprising given that both National Education Alliance for Borderline Personality Disorder and NAMI have historically exerted serious political influence on lawmakers. In the case of NAMI, a House resolution on borderline was a relatively minor political feat, considering political clout they have enjoyed since the mid 1990's when they were directed Laurie Flynn, whom President Clinton appointed to the National Bioethics Advisory Commission. As I mentioned previously, advocacy groups like NAMI have been under scrutiny for over a

decade for their industry ties. Thus, the current political status of borderline disorder may be a reflection of the particular goals of powerful moral entrepreneurship and disease mongering machines mentioned in chapter 5.

This is not to deny the potentially positive impact such a legislative statement might eventually produce. Indeed, attention by the National Institute of Mental Health (NIMH) into personality disorders has increased and legislative recognition of the importance of such research can only help to improve the chances of additional increases in research funding. NIMH funds were initially allocated to complement the significant work of Borderline Personality Disorder Research Foundation (BPDRF), which in 1999 began a programmatic effort to more fully examine the disorder and train researchers. Ultimately, the NIMH hopes to establish a more robust psychiatric nosology based on its Research Domain Criteria (RDoC) project, which "will build a framework for studying mental illness across basic dimensions of mental functioning – such as emotion and cognition. Cutting across traditional diagnostic categories, it will encompass multiple levels of analysis, from genes to neural circuits to behaviors."[4]

As both the lay public and politicians' recognition of the borderline continues to expand, demand for research and eventually a 'cure' will exert increasing pressure on policymakers to appropriate more funds toward those ends. From an ethical-pragmatic perspective, it will remain critically important to carefully examine the goals of this research enterprise, calling attention to underlying philosophical and political assumptions, as well as the arguably false promises such research may offer. One way to do this is through the processes of deliberative democracy. Without presenting an extensive description of those processes, we should note that the ideals of procedural

ethics exemplified by deliberative democracy are grounded on a patently pragmatic epistemology—though the varieties of such an epistemology are broad and varied. For purposes of addressing the ascription, treatment, and research into cases of mental disorder, we can again turn to feminist philosophy for guidance on such a process. For example, Susan Sherwin describes the need for deliberative democratic mechanisms to provide guidance on research priorities and trajectories:

> Research is a social and political activity, which has repercussions in our collective lives. Unless explicit attention is paid to the need for more democratic representation among the decision-makers responsible for research programs, the science that is carried out will continue to be, by and large, a science that supports the interests of the dominant groups in society. Scientists should recognize their complicity in perpetuating existing power structure and seek to increase their connection with, rather than distance from the subjects of their work. They should see themselves as accountable to the population at large, not merely the institutions and corporations that support their work.[5]

Sherwin, who is of course not alone in proposing this imperative for 'communicative equality', argues the demographics of research subjects should reflect the needs and concerns of those who most need the help.[6] She argues that the institutions of medical funding and research—such as NIMH—are currently and inadequately representative. It is therefore essential that policies establish mechanisms of participation by individuals who suffer from borderline disorder either as patients or family members.[7] An overreliance on monolithic advocacy groups, which are funded and, in some cases,

managed by biomedical research firms will only stifle a more ethically justifiable understanding of the irreducibly complex nature of borderline disorder, the influence of power and social structures on its etiology, and efficacious treatments.

As Sherwin suggests, direct and respectful lines of communication to community based advocacy groups—ideally groups that are less dependent on industry funding—would go far to engender both trust and robust discussion among researchers, policy makers, patient populations, and advocates. However, simply pointing to industry ties as grounds to disparage and ignore the important work done by groups like NAMI would be imprudent. Rather, critical examination of the role of those ties on organizational governance and decision-making should be intensified and made more transparent. Moreover, in the case of mental illnesses such as borderline, it seems that a key task will be to encourage the growth of a stronger grassroots network of patients and families, perhaps communicating via blogs and social networking platforms, all aimed at providing an alternative narrative to the political-industrial pronouncements that arguably oversimplify their experience of suffering. It will be interesting to see how these emerging forms of communication and political organizing will shape and reshape the concept of mental disorder. In fact, the DSM-V website includes an open forum for public comments and feedback. It remains to be seen how useful public feedback on manual changes will prove to be. How should public concerns about the re-categorization or the deletion of disorders be considered? Will public outcry be taken as seriously as evidence-based proposals about the reliability and validity that support reclassification?

Future research and scholarship will be needed to hone deliberative democratic processes for particular cases in which stakeholders might not have the ideal or 'rational' voice required to participate in the procedures established to collect public comment. Indeed, critics of classical democratic deliberation, such as Iris Young, have argued that only the privileged have a voice in the deliberative processes. The reclassification of mental disorders like borderline—where patient/stakeholders are often marginalized as irrational by virtue of their disorder—may offer a case study on the limits of standard modes of democratic deliberation.

A current analogous case to monitor involves another boundary case of mental disorder: Asperger's syndrome. A heated debate has ensued about the APA proposal to situate Asperger's squarely within the category of autism spectrum disorders. The key characteristics of Asperger's are socially determined. They include an inability to pick up on social cues, an aversion to changes in routine, and a preoccupation with very specific subject matters. Many adults with Asperger's, though they struggle with social interactions, are gainfully employed and lead relatively happy lives. Thus, some Aspergians and their advocates argue that subsuming the disorder within the autism spectrum will stigmatize a set of unique capabilities—things like extraordinary mathematical skills—that are actually a source of pride.[8] DSM researchers, in general, argue that the current diagnosis of Asberger's does not reflect evidence that it is a high-functioning variation of autism. Therefore, they argue, as a stand-alone diagnosis, Asperger's is often misunderstood both by clinicians and patients. The ongoing debate about Asperger's might provide insight into the ways reclassification of mental disorders

will occur, as it will test the limits and coherence of movements aimed to democratize the classification.

Reasonable Accommodation: 'Mad' versus 'Bad' Redux

Another significant policy implication resulting from the broadening diagnostic and political recognition of boundary cases like borderline is directly related to the scope of the Americans with Disabilities Act (ADA) and Family and Medical Leave Act (FMLA). As borderline disorder is more widely diagnosed and considered to be a biologically based brain disease, there will be increasing calls for reasonable accommodations for patients in a variety of public settings from places of employment to schools. Surprisingly, there has been very little written on this possibility and experts with whom I have communicated have yet to encounter cases involving patients who are seeking ADA accommodations or making social security claims based on their diagnosis of borderline personality. It is my sense this relatively quiet state of affairs is the calm before the storm.

Even a cursory search of blogs on borderline disorder will turn up discussion threads such as the following, in which patients describe their limitations in maintaining healthy interpersonal relationships and argue for employer accommodations:

> makeshift14: I have been diagnosed as having Borderline Personality Disorder, Generalized Anxiety Disorder, and Dysthemic Disorder. These three combined are believed to have caused my memory loss. My IQ is extremely high according to my psychotherapist who did a three day intensive test session with me. My psychotherapist feels that I would benefit from letting my work know I have Borderline Personality Disorder

because I need less distractions, written and verbal instructions, and positive criticism. Negative criticism may cause me to act on impulse. I know Florida is an at will work state and the ADA does have protections outlined for mental disabilities. Although the best treatment is time and therapy, it is currently affecting my performance. I have a hard time making friends or maybe even appear quiet to a lot of people. I have always had a difficult time associating with people...If I come forward and tell work why I am having such a hard time in the position now, will they fire me for performance or will they move me to another vacant position that has less public interaction? I work in a very large call center and we have so many different positions there...I am extremely smart with computers/electronics/typing/writing. My disability affects me in social interaction. I have close similarities to someone that has Asperger's disease.

inanightmare: I can give you some information based [on] experience. I went through much the same as you. My new boss had put me in a noisy area and he was highly critical of me, even though I had been an exceptional performer for nearly 9 years (always in a quiet environment, though). I explained my issues to my new manager and the next thing I know, he steps up the pace, being even MORE critical, putting me in an even noisier environment and doing other things that were right out of the mental disabilities "do not do" handbook. My performance continued to decline. I attempted to get additional accommodations to help this

> manager understand my limitations, but to no avail. I was terminated within 6 months. I got a lawyer for awhile (until I was broke) and have spent a year trying to fight for my rights, but it has been a lost cause. My suggestion is to step cautiously. I dotted my i's and crossed my t's with every step, but I still got fired.[9]

This thread reflects what I believe will be a larger trend in cases of borderline personality disorder. As public recognition broadens, stigma may decrease, allowing patients with borderline to 'come out' and insist that the problems they have been encountering in their lives are the result of a 'disease'. From the perspective of our pragmatic theory these demands seem to be both predictable and reasonable. If borderline should be considered an instance of mental disorder as any other, then it seems it should be covered under policies such as the ADA. But what guidance would our pragmatic theory offer to such difficult cases?

According to the pragmatic theory, demands such as the one described in the above thread should not be met with a categorical and uncritical affirmation. Recall, the theory aims to minimize the suffering of both the patient and those with whom she may affect. Thus, both employers and borderline employees have respective duties to properly manage the contentious situation. Employers would be responsible for negotiating an ethically justifiable solution that takes into account all who are affected, measuring the costs and benefits of reasonable accommodation versus reassignment or termination. In a workplace where individuals generally complete tasks independently, a worker who has borderline personality disorder might be perfectly suitable and highly competent to successfully meet her responsibilities. Though there could be instances of

interpersonal difficulties, if managed correctly by both the employer and employee, these could be diffused to avoid significant organizational strife.

In contrast, environments where functional teamwork is critical to success after a period of reasonable accommodation, employee reassignment or termination might be preferable if the dysfunctional behaviors prove to be refractory. One might argue that interpersonal skills are just that—skills—and as such employers can justifiably demand a certain level of competence. Of course such a demand must be made carefully and the onus should be on the employer to prove they have attempted in good faith to reasonably accommodate their employers psychological needs. (It should be noted that because of employer-based health care, termination could have a profoundly adverse effect on the long-term health of the individual.) In fact, we might adapt several of the virtues (i.e. authentic beneficence, trustworthiness, empathy, uptake) described in chapters 5 and 6, as well as Potter's full set of communicative virtues, that were proposed to guide clinicians in their diagnosis and treatment of borderline. Although we must recognize that the context, relationships, and power structures that circumscribe the problematic borderline behaviors are dramatically different, cultivation of these virtues might provide the needed skills and strategies to employers who genuinely intend to accommodate employees diagnosed with borderline personality disorder.

I should quickly mention one obvious difference between the patient-clinician relationship and the employee-employer relationship. While patients have a particular responsibility to participate in therapy and to try to get better, the borderline employee, it would seem, has a different—perhaps greater—responsibility to help remediate the dysfunctional situation since they are making a claim on others for accommodation. As

therapies such as dialectical behavior therapy become increasingly effective and widely available, the employee should avail herself of such therapies, making a good faith effort to learn the skills she needs to function more competently in her particular work environment. Of course, the degree of responsibility or accommodation should be subjected to further analysis and debate. The question of how the pragmatic theory might help to address issues related to reasonable accommodations for persons with mental disorders is complex and will therefore be a topic of future research.

Expanding Access

Throughout chapters 5 through 7, I argued that the pragmatic theory of mental disorder entails a particular set of ethical criteria be met across the continuum of classification, diagnosis, and treatment of boundary cases of mental disorder. These ethical criteria were set out to provide mental health professionals a general roadmap for implementation of the pragmatic theory. In presenting these ethical considerations it was assumed that mental health services were available and would be modified to the extent suggested by the ethical subtheories. However, we should note that such an assumption is problematic given the state of health care. While mental health parity policies have made significant progress in expanding health services to the mentally ill, they remain woefully insufficient to meet the needs of this growing population. In fact, research suggests that both insured and uninsured patients encounter significant barriers to mental health care services. Thus, to provide a more coherent pragmatic theory of mental disorder we should look at ways to enhance access to the kinds of treatments that ascriptions of mental disorder necessarily require.

As previously described, community and family outreach programs such Assertive Community Therapies (ACT) and Dialectical Behavior Therapy-Family Skills Training (DBT-FST) courses offer promising ways to mitigate the effects mental disorders like borderline through interfamily support groups and psychoeducation of patients and family. It is difficult to ascertain precisely the availability of these services, though NAMI programs and services are widely available. In contrast, more intensive in-patient treatment programs are extremely expensive, are often only payable out-of-pocket, and are resource and time intensive for families, patients, and providers. One example is Gunderson Residence recently opened for treatment of adult women with borderline personality disorder.[10] Affiliated with McLean Hospital's Center for the Treatment of Borderline Personality Disorder, the Residence provides intensive therapy over the course of several weeks, with a minimum stay of 60 days. The treatment components include a variety of group and individual therapies and vocational and educational counseling. At present, the $850 per day cost and limited space is prohibitive for most patients. However, as a clinical pilot program, Gunderson Residence may someday provide more effective treatments, in more locations, at a lower price.

A similar proposal has been made to specifically repurpose the Patient Centered Medical Home (PCMH) model for mental health services. The PCMH model proposes that primary care providers act as the hub coordinating a holistic medical care team. The basic idea is to provide patients with streamlined access to needed specialists in a manner that is enhances communication across all members of the care team, thereby improving outcomes and hopefully also reducing costs. Because of the promised benefits of better outcomes with reduced costs and enhanced payments for providers, the PCMH model has

been well received by clinicians, patients and policy makers alike. In the case of severe and persistent mental illness however, the PCMH model faces some obstacles.

For example, Alakeson, et al. argue that most primary care providers lack the experience to properly manage, treat, and coordinate the care of patients with severe mental illnesses.[11] As a result, mentally ill patients might not receive the care they need. And even in a well functioning PCMH setting primary care providers may or may not have ready access to services such as assertive community therapy programs. As a result, relying on a medical home based in primary care for mentally ill patients may not be the best way forward. Instead, Alakeson, et al. propose the development of a specific form of medical home designed for mentally ill patients. These specialty care medical homes would rely on partnerships with primary care providers but would be mental health care providers would serve as the coordinating hub patient care. The key rationale for developing such a model is that it would provide mental health care in an "understanding and experienced environment."[12]

Critics might object that this model bolsters the stigma of mental illness by sequestering sick people in specialty homes where their array of medical problems are made secondary to their psychological illness. Alakeson, et al. reply that, "the goal in [creating a specialty medical home for mental illness] is not to reinforce the segregation of people with severe and persistent mental disorders, as some fear, but to identify the most expedient way to address their urgent health care needs."[13] I am sympathetic to this line of reasoning and to their proposal in general. A specialty medical home model for mental illness would in theory offer patients access to a team of highly competent mental

health practitioners first instead of second, and as a result, these specialists will be adept at managing the complex needs of this population.

Future Research

In conclusion, there is much work to be done at the intersection of philosophy of medicine, psychiatry, psychology, and public policy. This dissertation was an attempt to craft a pragmatic approach to more adequately understand instances of mental disorder that currently fall through the theoretical lacuna of standard nosological theories. My motivation for developing a set of pragmatic and ethical justifications to more clearly identify and treat mental disorders has been to establish a more solid foundation for better public policy. My hope was to set aside arguments concerning the metaphysical status of boundary cases that often give rise to questions about their legitimacy. Instead I argued that such questions distract us from the central problem: the behaviors in question cause suffering—a form of suffering that is potentially remediable by medical or psychological treatment. By shifting my study away from foundational claims about the *actual* status of mental disorders like borderline, I hope I have redirected philosophical attention to the problem of the behaviors as such. I have no illusions that my theory is without rough edges. Indeed, key issues that I intend to continue to investigate in my future research include the following conceptual questions:

- Do the ethical subtheories and considerations I have proposed, and those in the literature I have reviewed, ensure (to the greatest extent possible) that pragmatic ascriptions of mental disorder are made in ethically justifiable manner?

- From a public health perspective, what is the scope of suffering—either in terms of individual persons or in terms of intensity of suffering—that is acceptable or unacceptable before considering a disorder a candidate for a pragmatic ascription of disorder?
- How might a pragmatic ascription of disorder affect the way we think about freedom and responsibility and what will the ramifications be for criminal justice?

Related to these conceptual questions are empirical ones that, if answered, would help implement the theory and provide evidence of its strengths and weaknesses. For example:

- Can a pragmatic ascription of mental disorder, properly understood by clinicians and caregivers, improve therapeutic outcomes and reduce stigma?
- Is a pragmatically motivated diagnosis, itself, therapeutic?
- What kinds of educational interventions for clinicians might be needed to implement the theory? How will these interventions be assessed?
- How might new scientific data on brain function, such as fMRI studies, affect our understanding of social dysfunction?

Such questions represent just a handful of many that will or could emerge when thinking about boundary cases of mental disorder in the way I have proposed. This dissertation is therefore a promissory note to pursue these additional lines of investigation.

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bipolar disorder, substance abuse, anxiety, and eating disorders; Whereas despite its prevalence, enormous public health costs, and the devastating toll it takes on individuals, families, and communities, BPD only recently has begun to command the attention it requires; Whereas it is essential to increase awareness of BPD among people suffering from this disorder, their families, mental health professionals, and the general public by promoting education, research, funding, early detection, and effective treatments; and Whereas the National Education Alliance for Borderline Personality Disorder and the National Alliance on Mental Illness have requested that Congress designate May as Borderline Personality Disorder Awareness Month as a means of educating our Nation about this disorder, the needs of those suffering from it, and its consequences: Now, therefore, be it Resolved, That the House of Representatives supports the goals and ideals of Borderline Personality Disorder Awareness Month.

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6. Janet Farrell Smith, "Communicative Ethics in Medicine: The Physician-Patient Relationship," in *Feminism and Bioethics: Beyond Reproduction*, ed. by Susan M. Wolf (New York: The Hastings Center, 1996),184-215.

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