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FRAMING THE CLINICAL AND PHILOSOPHICAL DIMENSIONS OF MENTAL DISEASE

By

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ABSTRACT

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To understand mental disease, I develop a coherentist framework, similar to the method of wide reflective equilibrium, initiated by John Rawls, developed by Norman Daniels to address questions of justice and extended by Kai Nielson and others to other ethical questions.

I introduce three critical elements of the framework, including metaphysical, epistemological, and ethical considerations, and when these elements become mutually supportive, fitting together as a unified whole, a better understanding of mental disease arises.

I first examine problems surrounding mental disease from historical, clinical, and philosophical perspectives and then begin to develop the coherentist framework by looking at conceptions of disease and the subject of disease – the person. I look at Christopher Boorse's non-normative conception of disease and H. Tristam Englehardt's normative conception of disease. I show that disease, and especially *mental* disease, have both non-normative and normative aspects. In practice, this conception of disease is useful for understanding patients as persons, who affect and are affected by disease.

To show how my framework works, I present some illustrations, including homosexuality, neurasthenia, and schizophrenia. I show that homosexuality, if viewed as a mental disease, does not fit among the clinical and philosophical dimensions of the

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framework, and thus should not be viewed as a disease. Neurasthenia, once known as "the national disease" in America, eventually disappeared because clinicians began to diagnose their patients with more precise disease classifications. Because neurasthenia no longer exists in Western medicine, some would argue it was never a disease but a useful social, political, and moral construction. Regardless of neurasthenia's disappearance, I show that it was a disease (and still is a disease in China). I finally describe schizophrenia, which is viewed as a myth by Thomas Szasz. To debunk Szasz's theory, I use the coherence framework and conclude that schizophrenia is not a myth but a disease. Through these illustrations I show that without a better understanding of mental disease, clinicians are unable to accurately and effectively classify, diagnose, and treat mental disease, and afflicted persons are blamed, pitied, ignored, and/or mistreated by others.

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CHAPTER 1

INTRODUCTION:

FRAMING THE CLINICAL AND PHILOSOPHICAL DIMENSIONS OF MENTAL DISEASE

Background

Understanding mental disease has been an ongoing challenge in medicine and in the sciences of the mind. Some theorists, like Thomas Szasz, go so far as to deny the reality of mental disease, claiming that madness is not a disease like measles and the field of psychiatry is nothing but a pseudoscience. Szasz states, "Psychiatry is conventionally defined as a medical specialty concerned with the diagnoses and treatment of mental disease. I submit that this definition, which is still widely accepted, places psychiatry in the company of alchemy and astrology and commits it to the category of pseudoscience."[1] The reason for this, Szasz believes, is that there is no such thing as mental illness.

Szasz and others who support this anti-psychiatry position fail to understand the views held by most clinicians, namely that "there is much 'physical' in 'mental' disorders and much 'mental' in 'physical' disorders"[2] and these mental and physical disorders are largely definable and classifiable. Clinicians and scientists would like to prove empirically that all mental disorders involve identifiable, physical malfunctions in the

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[1] Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper and Row, 1974), in *Medicine* by Roy Porter, (New York: Cambridge, 1996), 303.

[2] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision (DSM-IV-TR), (Washington, DC: American Psychiatric Association, 2000), xxx.

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body, presupposing that proper identification increases the likelihood of accurate diagnosis and successful treatment. However, what is being characterized and classified as mental disease does not always involve an identifiable, physical malfunction in the body. Instead, what is being characterized and classified is the array of psychological and behavioral symptoms experienced by the patient (e.g., hallucinations) without a full, *physical* explanation as to why or how those symptoms developed or how they can be effectively treated. Although, at some point, we may have a complete *physical* understanding of mental disease, without understanding the *mental* in mental disease, we do not have a complete picture as to the nature of mental disease as it affects and is affected by the patient. We can begin to develop a more complete picture of mental disease by viewing the disease as a feature of the whole person, including his or her human interactions with others (e.g., family, clinicians, etc.). With such a holistic approach, we can develop a better of understanding of both the conception of disease and the subject to whom disease is predicated.

According to Christopher Boorse, what makes a condition a disease is its deviation from the natural functional organization of the species.[3] Mental *disease*, as a non-normative concept, is a malfunction of a physical, bodily process localized in the brain or central nervous system. Mental *illness*, on the other hand, may be understood as a normative concept based on factors such as being undesirable for its bearer, a title to special treatment, and a valid excuse for normally criticizable behavior.[4] Part of my project will involve looking at these non-normative and normative conceptions. My aim

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[3] Christopher Boorse, "Health As A Theoretical Concept," (*Philosophy of Science*, 44, 1977), 542.

[4] Boorse, "On the Distinction Between Disease and Illness", (*Phl and Public Affairs*, 5 1975), 61.

is to show that mental disease, like physical disease, is not a normative concept entirely, nor is it what Boorse characterizes as a "theoretical" or non-normative concept. My approach to mental disease has both theoretical and normative aspects. Part of classifying and categorizing mental disease, which involves a physical malfunction in the brain and/or central nervous system (CNS), often depends on the subjective experience of the patient, e.g., the extent the phenomenon is undesirable.[5]

Mental disease cannot be fully understood simply by classifying the symptoms of disease in a diagnostic system, or by characterizing what mental disease *is* and how it affects persons using biological criteria, although this is a critical step. Szasz and his supporters set out to debunk mental disease by emphasizing those "diseases" that are constructed or invented for social and/or political purposes, e.g., Soviet psychiatry. Szasz refers to these fabricated diseases as "functional illnesses" in his 1974 book *The Myth of Mental Illness* (as opposed to structural diseases or physical diseases such as malaria). Functional illnesses were, for Szasz, identified by the various complaints or functional-behavioral alterations of the persons affected by them. If Szasz was correct in saying that mental disease is fabricated or constructed, then we need to understand why and how it is constructed. This is one approach for understanding the nature of mental disease and those persons who have, or are believed to have, such diseases. Nevertheless, I believe that genuine mental disease is not something that can be invented, even though it remains difficult to define, understand, and explain.

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[5] Boorse refers to this middle position as *weak normativism.*

So how do we understand mental disease? How do we know when we have achieved a genuine understanding? Will the social and ethical problems that accompany mental disease be resolved when we have a better understanding? We can start to answer these important questions by identifying various dimensions of mental disease under one organized framework. With this framework, we then can obtain a better understanding of what mental disease is, how it differs from and is comparable to somatic diseases, and how it *ought to be* diagnosed, treated, and understood from a clinical, social, and ethical perspective.

The Methodology

This dissertation identifies several aspects of mental disease, which I hope to fit together as a unified whole in order to provide a workable framework for better understanding mental disease. I hope, too, to show why this understanding is *ethically* significant for clinicians, patients and their families. Specifically, I am proposing to adapt the model of wide reflective equilibrium (WRE), employed in ethical and political philosophy, to organize these various aspects into a workable framework.[6]

An adequate understanding of mental disease, descriptions, characterizations, and classifications must reflect not only clinical and scientific observations of mental disease, but must also reflect patients' somatic and psychological experiences. In developing a

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[6] A type of coherence theory, wide reflective equilibrium in ethics, has three main components: moral judgments, background beliefs and theories, and ethical principles. These three components are in a reflective equilibrium when they are mutually supportive, fitting together as a unified whole. The unified whole provides a substantive moral framework through which new cases and unconsidered situations are addressed. The model of wide reflective equilibrium combines commitment to some views with the possibility of more or less radical revision.

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framework for understanding mental disease from a holistic point of view, I look at the metaphysical and epistemological considerations of mental disease, as well as, corresponding ethical considerations.[7] In the next chapter, *Framing the Problem*, I describe each of these three considerations, and then show why these considerations are necessary for developing a better understanding mental disease. In brief, without a better understanding of mental disease, persons are likely to be mistreated clinically and/or socially, and those, such as caregivers and families, may be wrongfully blamed for causing the disease, or blamed for not effectively helping or developing meaningful relationships with the patient.

Using my proposed framework to illustrate the complexities of mental disease, I illustrate problematic cases where diseases are (or were) thought to be myths (because of their vague diagnostic criteria and lack of pathology) rather than genuine diseases. I examine the metaphysical, epistemological, and ethical dimensions of particular cases of disease to illustrate how this coherence framework provides a promising methodology for understanding the various clinical and philosophical dimensions of mental disease and for understanding persons who are diagnosed with mental diseases.

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[7] To frame the epistemological, metaphysical, and ethical considerations of mental illness, I will not be using a traditional method of WRE, or the method that produces coherence in an ordered triple of sets of beliefs held by a particular person including; moral principles, moral judgments, and background beliefs and theories. I develop a framework similar to WRE to develop a better understanding of mental disease based on the aforementioned interrelated philosophical considerations. In chapter 4, I put this dynamic framework in motion to illustrate how equilibrium is retained, lost, and regained as new, unconsidered, or problematic situations and/or information arise.

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New, Unconsidered, or Problematic Cases

In using this coherence framework, in chapter 5, *Myth or Madness?,* I present three illustrations of the framework as it applies to homosexuality, neurasthenia, and schizophrenia, respectively. In the first illustration, I explain that homosexuality, first viewed as a sinful, sexual perversion, was then classified as a disease to suggest that homosexual individuals did not function properly due to some biological flaw which could be treated. Many homosexual persons were forcibly treated, even though there was no empirical evidence to suggest homosexuality could be treated. Because no etiology could be found, treatments were ineffective, and homosexual groups strongly opposed such treatments, homosexuality was eliminated from the DSM prior to its third edition in 1974. Even though homosexuality has been eliminated from this classification system, I use the framework to provide a more comprehensive account to show why homosexuality is not a disease; the conception of homosexuality as a disease is unable fit the framework (even when modifications are made).

The second illustration, neurasthenia, a functional nervous disorder, is a problematic case since it was removed from classification systems and has been said to have "disappeared from existence". Because neurasthenia no longer exists, many believe it is not, and never was, a disease. However, through the coherence framework, I show that neurasthenia is (or was) a disease even though it is no longer classified in the DSM. Schizophrenia has not been wholly defined or explained, although patients with schizophrenia experience disturbing symptoms such as hallucinations and delusions. Because the etiology of schizophrenia is obscure, some, like Szasz, believe it is not a disease but a myth. Again, I show, using the coherence framework, that schizophrenia is a disease based on the best "fit" of mutually supportive metaphysical, epistemological, and ethical considerations. The following descriptions of homosexuality, neurasthenia, and schizophrenia, give a better sense of the philosophical and clinical difficulties in determining whether these examples are diseases or myths.

A. Homosexuality

For several centuries homosexuals were jailed or even sentenced to death, since homosexuality was viewed as a sin. Religious and political figures believed that homosexuality violated certain values surrounding procreation and family. By the end of the 19th century homosexuals were no longer viewed as sinners but persons with a disease. Thus, homosexuality became labeled a disease, which alleviated, to some extent, the culpability of the homosexual individual. Instead of directly blaming the individual, medical and scientific personnel started to place blame on unidentified physical and/or psychological malfunctions or abnormalities in the brain.

Although this picture has slowly faded, i.e., no pathology has been found, some still believe homosexuality is a mental disease, since homosexuals do not conform to social norms or values. However, calling a person diseased because he or she does not conform to society raises several philosophical problems not to mention inviting the wholesale criticism of Thomas Szasz. For one, if homosexuality is viewed as a disease based on the values of society, the diagnostic criteria for what is or what is not a disease become arbitrary, possibly harming the patient who holds different values. This was seen in the case of Alan Turing, a mathematician and philosopher who was mistreated because of his homosexuality. In order to change his sexuality and "cure his disease", Turing received forced hormone treatments. Because new information about homosexuality was brought to light, e.g., the harmful effects of treating homosexuality as a disease, the elements of the framework need to be modified.

B. Neurasthenia

In 1869 the neurologist George Beard had first described neurasthenia, a functional nervous disorder characterized by profound physical and mental exhaustion. Some of the many "slippery, fleeting, and vague" symptoms of neurasthenia included headache, noises in the ear, insomnia, flushing and fidgeting, deficient mental control, nervous dyspepsia, vague pains, and spinal irritation, just to name a few of the possible fifty-two.[8] Neurasthenia, which was once known as "the national disease" in America during the late 19th century, disappeared in the early 20th century due to several factors. For one, no pathology could be found. Also, a number of the symptoms characterizing neurasthenia occurred in other classifiable diseases, making diagnosis and treatment difficult. As Barbara Sicherman points out, "The diagnosis had become so widespread, its use so imprecise, that many physicians believed it had outlived its usefulness."[9] What is interesting to point out, however, is why neurasthenia was *so* useful during the late 19th century.

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[8] Barbara Sicherman, "The Uses of Diagnosis: Doctors, Patients, and Neurasthenia," in *Sickness and Health in America*, by Judith Walzer Leavitt and Ronald L. Numbers (Wisconsin: The University of Wisconsin Press, 1985), 22.

[9] Ibid., 24.

According to Sicherman,

> Neurasthenia proved a satisfactory label to doctors and patients alike. By incorporating into a disease a picture of a host of behavioral symptoms, many of which would otherwise have been deemed self-willed and thus deviant, the diagnosis legitimized new roles for physicians and their patients...certainly it was preferable to its nearest alternatives- hypochondria, hysteria and insanity, not to mention malingering.[10]

The diagnosis of neurasthenia was useful for physicians for providing an essentially psychological therapy under a somatic label. With this somatic label, physicians were able to 'identify' and understand what was wrong or abnormal with their patients. Sicherman captures a common therapeutic problem within the doctor-patient relationship by stating, "If the physician fails to make sense of the patient's troubles – or to relieve them- neither he nor his patient will retain much confidence in his skill."[11] Although neurasthenics suffered from symptoms similar to the insane, neurasthenics were not always treated similarly. In fact, social and economic standing influenced diagnostic decisions. Upper-class patients suffering from hallucinations were often diagnosed as neurasthenic. However, a patient with similar clinical problems, as

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[10] Ibid., 25.

[11] Ibid., 25.

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[2] Ibid., 27.

Sicherman tells us, but with "fewer financial resources and less loyal family and friends, might have been declared insane and placed in an asylum."[12]

Neurasthenia is one particular case illustrating the difficulties of diagnosing and treating patients, since it characterized too many symptoms with no specific disease pattern. Because of these clinical difficulties, ethical and social problems often develop concurrently. The inability to discern the nature of mental disease medically, ethically, and socially affects the clinician, patient, and his or her family. For example, a patient who was diagnosed with neurasthenia and who displayed the same pattern of symptoms as someone else who was labeled with a different disease, may have been treated differently (e.g., bed rest and a specific diet instead of compulsory institutionalization). The vast difference between diagnostic and treatment practices not only questioned the authority of the clinician, but raised social concern as to which treatment was the better one and why. Without having reliable descriptions, characterizations, and classifications, we cannot understand mental disease or persons who are diagnosed as having such diseases. The case of neurasthenia is an excellent example for showing the clinical and philosophical complexities of mental disease. Such an example also reveals how a coherence framework can organize the various dimensions of mental disease to guide us into making appropriate ethical and social decisions (even if those decisions include eliminating the diagnosis of neurasthenia from clinical practice). Nevertheless, in order for my investigation to be relevant today, I need to look at examples in which the categorizations, diagnoses, and treatment practices of presently classified mental diseases

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[12] Ibid., 27.

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are unclear, raising important clinical and ethical concerns regarding how these diseases are defined and those who are defined by them. One such example is schizophrenia.

C. Schizophrenia

In 1911 schizophrenia was termed to signify a schism between thought, emotion, and behavior. The symptoms of schizophrenia usually include impairment of thinking, hallucinations, delusions, and changes in emotion and behavior that can vary from patient to patient. Patients can also have varying courses of disease and responses to treatment. According to the authors of the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-IV-TR), "No single symptom is pathognomonic of schizophrenia; the diagnosis involves the recognition of a constellation of signs and symptoms associated with impaired occupational or social functioning."[13]

Because of variability in clinical presentation, the severity of disease, the course of disease, and response to treatment, physicians and researchers have been unable to determine the exact etiology of schizophrenia. Although the etiology of schizophrenia is unknown, considerable knowledge has accumulated about the disease. For instance, it is known that schizophrenia affects the limbic system of the brain. There is also evidence to suggest that schizophrenia is hereditary and that damage to the brain may occur in the early stages of life.[14] Philosopher Ian Hacking claims, "It is not claimed that every person now diagnosed will have the same problem. In the case of schizophrenia, some

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[13] American Psychiatry Association, 299.

[14] E. Fuller Torrey, *Surviving Schizophrenia: A Family Manual* (New York: Harper and Row Publishers, 1988), 129.

researchers conjecture that there are at least two distinct disorders, one of which declares itself in late adolescence and is genetic, and another which may not be inherited."[15]

A cure for schizophrenia has not been found. Patients afflicted with the disease not only suffer from its terrifying symptoms but they may also suffer from the knowledge that schizophrenia is an incurable disease.

As one can see, schizophrenia is complex in that it cannot be wholly defined or explained, although those who are diagnosed as having schizophrenia are experiencing disturbing symptoms. We may be able to change how we define, classify, or categorize mental disease (and those who have been diagnosed as having such diseases); however, stigmatization often remains, partially due to a general lack of understanding of what mental disease is. By exploring the historical legacy of neurasthenia and contemporary, questionable diseases such as schizophrenia, I hope not only to find a suitable understanding of mental disease, but also to gain an awareness of the meaning of disease, as understood, properly and/or improperly, by clinicians, patients, families, and society. The moral judgments we make and the ethical principles we follow depend on how we understand and explain the metaphysical and epistemological dimensions of mental disease and vice versa.

In the next chapter, *Framing the Problem*, I examine more closely the problems associated with having an inadequate understanding of mental disease and those who suffer from mental disease. I also look more carefully at the metaphysical, epistemological, and ethical considerations with respect to clinical classification,

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[15] Ian Hacking, *The Social Construction of What?* (Cambridge: Harvard University Press, 1999), 117.

diagnostic, and treatment practices and show why these considerations are important for constructing a coherent framework for developing a better, more comprehensive understanding of mental disease. This chapter provides the necessary historical, philosophical, and clinical background for the fourth chapter, *The Diseased Embodied Mind*, which sets the coherence framework in motion, showing how metaphysical, epistemological, and ethical consideration become mutually supportive.

CHAPTER 2

FRAMING THE PROBLEM:

PROBLEMS AND QUESTIONS SURROUNDING THE NATURE OF MENTAL DISEASE

Introduction

"Mental" and "disease", two, simple words that, when placed together, create an image in our minds, an image we have drawn from past experiences, novels, films, or stories, written before we were born, and retold by our peers. We may see in our minds an unkempt human being, roaming the streets alone, talking to himself in strange tongues, and behaving in ways that make us fear him, loathe him, or even pity him. In describing this human being, further words stream from the mind, words such as "crazy", "lunatic", "deranged", "mad", and so forth. Reflecting upon this image we have constructed in our minds, we are left with numerous questions. Why do we construct such images of mental disease? What exactly *is* mental disease? Who are the mentally diseased? How do we know if persons are mentally diseased or just eccentric?

This chapter attempts to examine some of these questions for purposes of constructing a comprehensible framework through which we can begin to acknowledge and understand the various dimensions of mental disease. By investigating the experiences of the mentally disturbed person, we can begin to build our philosophical framework, and construct a better, comprehensive understanding of mental disease. A better understanding can reduce stigmatization, improve the accuracy and consistency of clinical diagnostic and treatment practices, and develop social awareness of and responsibility for those persons with mental diseases. Once we have a better, comprehensive understanding of mental disease, perhaps the images we construct in our minds, and the emotions that follow, will be replaced with different ones, which are more sensitive to the sufferer and to the body of knowledge that defines mental disease.

This chapter lays the groundwork through its explanation of the philosophical and clinical problems correlated with a poor understanding of the nature of mental disease. In the first section of this chapter I show, through historical accounts, why mental disease has been difficult to define, classify, and understand. I then introduce those philosophical elements I believe to be essential for understanding mental illness and disease, namely, metaphysical, epistemological, and ethical considerations. In this section, I also examine some of the recent problems surrounding clinical classification, diagnostic, and treatment practices. In subsequent chapters I show that these philosophical dimensions hang together to form a more comprehensive conception of mental illness and disease.

Historical Background

In the Hippocratic tradition of the Greeks, insanity was "couched in terms of physical causes and effects", emphasizing malfunctions in what were known as the humors, or essential body fluids, including black bile, yellow bile, phlegm, and blood.[1] The health of a person hinged on these four essential fluids in the body; too much or too

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[1] Roy Porter, *Medicine* (New York: Cambridge University Press, 1996), 280.
Several words signifying mental disease have been used throughout history such as insanity, madness, lunacy, irrationality, craziness, and derangement. Many of these words developed from observable, unusual or abnormal behaviors expressed by persons who were mentally diseased or who were thought to be mentally diseased.

little of one or more of these fluids was likely to cause a person ill health or disease, including mental disturbances. For example, an excess of phlegm collects in the nose and throat when one has a cold, causing the person to be dull or sluggish or an excess of yellow bile would overheat the system, causing mania or raving madness. Hippocratic medicine was an attempt to explain health and disease by looking at the human body as a system, replacing supernatural explanations with natural observations and theories. All diseases of the body and mind were thought to be malfunctions or abnormalities of bodily processes; disease was not a supernatural phenomenon controlled by angry Gods or spirits, even though it was often difficult to explain.

Although the Hippocratic tradition continued well into the 18th century, looking at disease as a natural humoral imbalance within the body's system, society did not always support or place great emphasis on humoral theories of disease.[2] Instead of explaining disease using scientific theories and methodologies, disease was often explained by society as a punishment for sinful behavior. It was believed that the madman acquired a disease because he or she (or a close relative) did something immoral. For example, if a child were cognitively impaired, e.g., unable to speak, the mother was often blamed for having caused the impairment under the unsupported assumption that she did something immoral while she was pregnant. Moralizing

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[2] Evidence supports that aspects of humoral medicine continued even after the 16th century. Robert James published the *Medical Dictionary* in 1743 proposing that "It is evident that the brain is the seat...of all diseases of this nature...It is there that the Creator has fixed, although in a manner which is inconceivable, the lodging of the soul, the mind, the genius, imagination, memory, and all sensations...All these noble functions will be changed, depraved, diminished, and totally destroyed, if the blood and the humors corrupted in quality and quantity are no longer carried to the brain in a uniform and temperate manner, but instead circulate there with violence and impetuosity, or move about slowly, with difficulty or with languor." Foucault, Michel. *Madness and Civilization: A History of Insanity in the Age of Reason,* translated by Richard Howard (New York: Vintage Books, 1988. First published 1961), 123.

atypical behaviors and observable physical abnormalities affected diagnostic and treatment practices, especially during the 17th and 18th centuries.

A. Immorality Confined

Throughout the 17th and 18th centuries, Hippocratic humoral medicine was slowly replaced by mechanistic theories, viewing the body as a machine and mental disease as a defect of the sense organs and their nervous networks.[3] Philosopher Rene Descartes, with others during this time, suggested that madness was an irregular agitation of the animal spirits, a disordered movement of fibers in the brain. So, for example, instead of melancholia being explained as an excess of black bile, it was explained as a mechanism of fear and a circulation of spirits peculiar to sadness. The insane were often compared to animals, creatures that, for Descartes, lacked the ability to reason. The madman who spoke in strange tongues or did not speak at all enforced the view that he was a mere animal, a being who did not have a genuine language, and thus could not function as man.[4] Foucault writes,

> During the classical period, madness was shown, but on the other side of the bars; if present, it was at a distance, under the eyes of a reason that no longer felt any relation to it and that would not compromise itself by too close a

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[3] Porter, *Medicine*, 283.

[4] According to Descartes, having a genuine language suggests that one has a capacity for responding in complex ways.

> resemblance. Madness had become a thing to look at: no longer a monster inside oneself but an animal with strange mechanisms, a bestiality from which man had long since been suppressed.[5]

John Locke believed that mental disease was a defect in logical processing; those who were 'mad' could not make distinctions between what was real and what was imaginary. Because the insane had an uncontrollable imagination, there was the underlying assumption that they could not determine right from wrong; the insane were deemed defective *and* immoral. Due to these mechanistic theories of madness in the age of reason, combined with society's loathsome fear of difference, the 'mad' were separated from the rest of society and forcefully confined to mental institutions or madhouses. Historian Roy Porter writes, "Elements in society identifiable with 'unreason' found themselves at risk of being locked away. Paupers, the aged and ill, ne'er do wells, petty criminals, prostitutes, and vagabonds formed the bulk of this horde of 'unreason'."[6]

In *Madness and Civilization*, Foucault describes how society, in the age of reason, viewed the mentally insane as social outcasts, locked away from the rest of the world. In his interpretation of Foucault's view on madness, Grant Gillett writes,

> He (Foucault) observes that our medical attitude to insanity is an initial distancing so that madness becomes a kind of

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[5] Foucault, 70.

[6] Porter, *Medicine*, 287.

> otherness from right thinking and therefore we do not seek to understand it, rather we attempt to control it. Our forms of control allow us to treat the insane as cases or instances of certain kinds of human aberration and to begin the objective study of these aberrations from the point of those who dominate and distance themselves.[7]

At the start of the 18th century, clinicians started to take the mechanistic theories of the 17th century seriously. Clinicians and scientists developed medical models of disease based on the mechanics of the human body and mind. In the asylums, restraints that were once used to control the insane (e.g., straitjackets, chains, etc.) were replaced with more therapeutic measures. Porter explains, "The madhouse was not just to secure but to cure"[8] Psychiatrists, using the madhouse as a research institution for clinical practice, developed their medical and scientific theories and were able to test their hypotheses and newly established treatment practices on the inmates. The problem, however, was that many of the individuals who were confined to the madhouses were not actually mentally diseased or ill. Foucault writes, "Hence an abyss yawns in the middle of confinement; a void which isolates madness, denounces it for being irreducible, unbearable to reason; madness now appears with what distinguishes it from

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[7] Grant Gillett, *The Mind and its Discontents* (Oxford: Oxford University Press, 1999), 56.

[8] Porter, *Medicine*, 293.

all these confined forms as well. The presence of the mad appears as an injustice; but *for others*."[9]

Toward the end of the 19th century, the insane were not being effectively treated and asylums became overflowing with chronic patients. Clinicians no longer focused on trying to help the individual. Instead, clinicians and scientists were determined to find the causes of madness and focused more on classifying and categorizing the various mental disturbances they observed in the asylums. Porter explains, "Psychiatry successively staked greater territorial claim to 'discovering' mental disease where it had not been suspected before."[10]

B. Medicalizing Madness

Loretta Kopelman writes, "As a result of early work in psychiatry, the behavior of the "lunatics" was reclassified from moral categories such as sinfulness to medical categories of sickness."[11] She explains how the founders of modern psychiatry such as Sigmund Freud, addressed the problems associated with society's perception of those who were deemed "mad". Instead of moralizing the behavior of the mentally disturbed, mental illness was classified as a medical problem with a physiological basis.

For example, during the 18th and 19th centuries, the once believed immoral behavior of masturbation was transformed into a disease with somatic and

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[9] Foucault, 228.

[10] Porter, *Medicine*, 297.

[11] Loretta Kopelman, "Moral Problems in Psychiatry", in *Medical Ethics* by Robert Veatch, (Jones and Bartlett Publishers, 1989), 255.

psychological dimensions.[12] Masturbation was thought to cause various other illnesses such as blindness, impotency, memory loss, and insanity, just to name a few.[13] H. Tristam Englehardt writes, "In short, the concept of masturbation as a disease probably acted as a schema for organizing various signs and symptoms which we would now gather under different nosological categories."[14] The most invasive treatment of this "disease" involved removal of genitalia through surgical removal of the clitoris for women and either vasectomy or castration for men. There were other less invasive treatments including hard work, simple diets, cold showers, use of tonics, and even sexual activities (e.g., some clinicians recommended to their patients to frequent houses of prostitution).[15] Because clinicians and scientists did not understand what caused diseases such as blindness, they looked at masturbation, a socially unacceptable behavior, to be the single cause. Englehardt writes, "A sought-for coincidence of morality and nature gives goals to explanation and therapy. Values influence the purpose and direction of investigations and treatment."[16] Thus, carried with this medicalization process were the social and moral determinates of madness' ontological status.

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[12] H. Tristram Englehardt, "The Disease of Masturbation: Values and the Concept of Disease" in *Sickness and Health in America*, edited by Judith Walzer Leavitt and Ronald L. Numbers (Wisconsin: The University of Wisconsin Press, 1985), 13.

[13] Masturbation was just one of the diseases believed to cause blindness and other physical and psychological problems. For example, clinicians recognized that blindness was hereditary and was not always the result of masturbation.

[14] Ibid.,14.

[15] Ibid.,17.

[16] Ibid.,18.

Socio-political Psychiatry and the Making of Mental Disease

Englehardt writes, “A ‘disease entity’ operates as a conceptual form organizing phenomena in a fashion deemed useful for certain goals.”[17] Although theories of disease and its influence on mind changed as science and medicine progressed (e.g., movement from the humoral theory to the germ theory of disease and then to heredity/genetic theories of disease), these theories were governed by various social, moral, and political goals. Mental disease fought for recognition as a biological phenomenon rather than a mere justification for atypical social, moral, and political beliefs and behaviors. However, in some cases, the battle was lost.

By the early 20th century, asylum-based psychiatry started to diminish, and a greater emphasis was placed on prevention and treatment. For example, the eugenics movement, supporting the prevention of ‘idiocy’ in the United States and in Europe, was an attempt to prevent mental disease through compulsory sterilization practices.

Porter states,

> All societies judge some people mad: any strict clinical justification aside, it is part of the business of marking out the different, deviant, and perhaps dangerous. Such ‘stigma’, according to the American sociologist Erving Goffman, is ‘the situation of the individual who is disqualified from full social acceptance.[18]

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[17] Ibid., 18.

[18] Porter, *Madness: A Brief History* (New York: Oxford University Press, 2002), 62.

Those who were deemed socially "unfit", or 'disqualified from full social acceptance were forcibly sterilized, disabling them from passing on "bad genes" to future generations. However, most of the people who were forcibly sterilized were not 'idiots' or mentally diseased. They were, however, mostly poor and uneducated and some were alcoholics, criminals, epileptics, or persons with cognitive and physical impairments (e.g., those who were blind, deaf, and mute). Once again, society began to "diagnose" and "treat" those who were different, abnormal, and sick without a clear understanding as to what was being diagnosed or who was affected.

In 1927, Justice Oliver Wendell Holmes ruled that sterilization was constitutional and an effective way to eliminate "unfit" persons. This ruling originated from the Supreme Court Case, *Buck vs. Bell.* This Supreme Court supported the decision to sterilize Carrie Buck, who was raped and blamed for this 'indecent and immoral act'. Instead of calling Carrie a 'victim' of rape, she was branded as an 'imbecile'. Holmes declared that "three generations of imbeciles are enough", referring to Carrie, her mother, who was already institutionalized because of prostitution charges, and her illegitimate child named Vivian. Mental disease was seen as a hereditary defect that could be classified and controlled through social and political means, supported by a genetic theory of disease. Although there is well-supported scientific and medical evidence pointing to genetic causes of disease, the ethical nature of the sterilization programs in the United States and in Europe at the turn of the 20th century and the lack of evidence during this time, illustrates the social, moral, and political problems associated with a poor understanding of mental disease.

Another example of social and political influences on diagnostic and treatment practice is exemplified by Soviet psychiatry. In the 1960's psychiatry was used in the Soviet Union to repress dissidents who did not support the socio-political practices or goals of the government. "It has been used, non-Soviet psychiatrists claim, to involuntarily detain and 'treat' Soviets advocating human rights or nationalism for republics within the Soviet Union as well as persons seeking to emigrate, having religious convictions, or embarrassing the Soviet government."[19]

A diagnostic system, developed by Andrei V. Snezhnevsky, was implemented during the 1960's, differing from the Diagnostic and Statistical Manual and "not based on research that meets commonly accepted scientific standards." [20] The criteria used to diagnose and treat mental disease, especially schizophrenia, were so vague that people who were not mentally diseased or ill were diagnosed as such. Walter Reich describes how the Moscow School's diagnostic system focused on the mental illness schizophrenia. He explains that because the definition of schizophrenia was so extraordinarily broad, the definition "took in vast sectors of non-schizophrenic psychopathology – sectors that, grouped together, encompass much of the territory of mental illness."[21] The theory behind the system was based on the assumption that schizophrenia has three different forms, varying from each other in their course and their treatment.

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[19] Sidney Block, "The Political Misuse of Psychiatry in the Soviet Union" in *Psychiatric Ethics*, S. Block and P. Chodoff (eds.) (Oxford: Oxford University Press), 321-341 quoted in Kopelman "Moral Problems in Psychiatry," in *Medical Ethics*, Robert Veatch (ed.) (Boston: Jones and Bartlett Publishers, 1989), 262.

[20] Walter Reich, " Psychiatric Diagnosis as an Ethical Problem," in *Psychiatric Ethics*, 3rd edition, edited by Sidney Bloch, Paul Chodoff, and Stephen A. Green (Oxford: Oxford University Press, 1999), 197.

[21] Ibid., 198.

Reich writes,

> People were diagnosed as schizophrenic by trained psychiatrists. Those Soviet psychiatrists really *saw* the patients as schizophrenic; or, to put it another way, *the system created a category, first on paper and then, through training, in the minds of Soviet psychiatrists, which was eventually assumed to represent a real class of patients and which was inevitably filled by real persons.* Those diagnosticians came to see schizophrenic pathology as including very mild forms and diagnosed accordingly.[22]

Because the classification system, developed and proposed by Snezhnevsky, was adopted into clinical practice and used as *the* method through which psychiatrists diagnosed and treated their patients, several people were wrongfully confined to mental institutions for the criminally insane and "treated" with pharmacological, surgical, and behavioral manipulations of the brain. The classification system, along with the use of trained "expert" psychiatrists, supported social and political goals for removing dissidents from the streets of the Soviet Union. Dissidents were routinely arrested. Reich writes, "Some of them (dissidents) were then sent by the KGB, quite cynically, to psychiatrists, learning of the KGB's wish that the dissidents be found mentally ill, did indeed find them ill, often giving them as a diagnosis one of the categories of mild

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[22] Ibid., 202.

schizophrenia."[23] Not only were dissidents forced into confinement against their will, they were unjustifiably treated on the basis of juridical decisions, supported by "evidence" of their having a mental disease. Reich states, the legal trials were held without the dissidents, and as a result, "they could be sent for indeterminate amounts of time to hospitals for the criminally insane, and their views could be depicted as the sick products of sick minds."[24] The essential problem with Soviet psychiatry was the inaccuracy and inconsistency of the classification system used as the sole basis for training psychiatrists and for executing psychiatric diagnostic and treatment practices.[25]

Theories and interpretations of disease continue to develop, corresponding with advances in technology, knowledge about the human body and its functions, and the identification of etiological entities responsible for infections, defects, and lesions of the body. However, to this day we still do not have a comprehensive understanding of mental disease, which often results in poor diagnostic practices, ineffective treatments, and stigmatization. In an attempt to develop a comprehensive understanding, we need to think critically about the philosophical dimensions of mental disease, asking important metaphysical, epistemological and ethical questions.

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[23] Ibid., 204.

[24] Ibid., 204.

[25] In the next section, a closer look at the philosophical problems associated with contemporary classification and diagnostic systems will be given.

Philosophical Dimensions of Mental Disease

Whether one is reflecting on past cases of mental illness and disease or is analyzing new ones, one particular question clinicians often ask is, does this person have a mental disease? A clinician may diagnose a person with a mental disease or illness, but this does not mean the individual has an actual disease. A diagnosis may be poor if the criteria used for diagnosing patients have no scientific basis, as demonstrated by Soviet psychiatry in the mid-20th century, if the clinician has made an error (which may have something to do with his or her training or lack thereof), or if social, moral, and political values get in the way of objective scientific measurement and analysis, as evidenced by the case of *Buck vs. Bell.* Poor diagnostic practices contribute to, or are a result of, wrongful and inaccurate characterizations and classifications of mental diseases. If we improve our diagnostic and classification practices, making them more accurate, reliable, and consistent, a better safeguard against social, moral, and political abuse would ensue. Improving our diagnostic and classification practices improves the overall welfare of persons with or without mental disease. However, this cannot be done without a better, more comprehensive understanding of mental disease and illness. In order to achieve a better, more comprehensive understanding, we need to address and analyze the philosophical dimensions of mental disease. In this analysis, it is important to identify and distinguish what is disease, which phenomena count as diseases, and how do we determine when a person is diseased.

Wilfrid Sellars' characterization of philosophy as "an attempt to see how things, in the broadest possible sense of the term, hang together, in the broadest sense of the term,"[26] captures the essence of my overall project - to see how metaphysical, epistemological, and ethical dimensions of disease, especially mental disease, hang together in the broadest possible sense. However, in constructing a more comprehensive account of mental disease some aspects may need to be modified in the light of others. I show in subsequent chapters how conceptions of mental disease are modified in light of new, problematic, or previously unconsidered situations or information.

The figure below is a rough sketch of the coherence framework and those philosophical dimensions, including metaphysical, epistemological, and ethical considerations, which contribute to a better understanding of mental disease when becoming dynamically interrelated. Although the metaphysical, epistemological, and ethical dimensions are intended to be viewed as a coherent whole, for the purposes of illustrating how each dimension plays a unique role, I describe them individually throughout this chapter, beginning with metaphysical considerations.[27] In chapter 4, *The Diseased Embodied Mind*, I show how these dimensions mutually support and are supported by each other, thus developing a dynamic rather than a static coherence framework.

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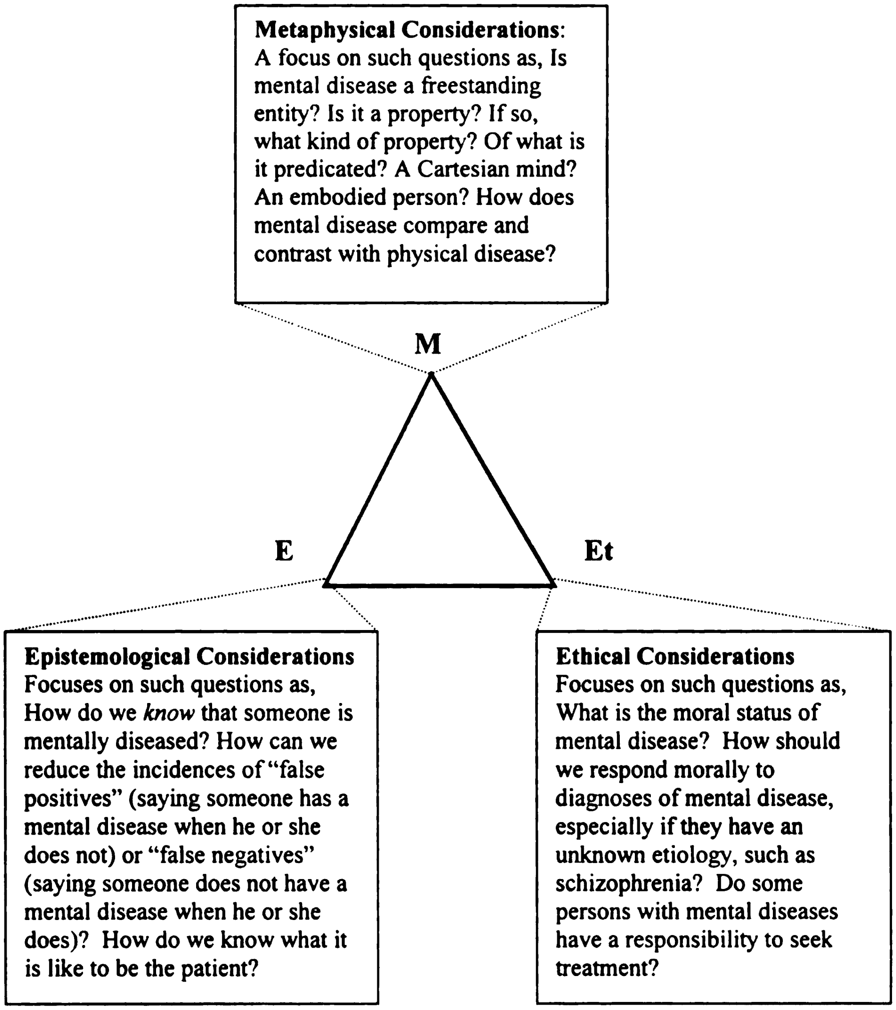
[26] Wilfrid Sellars, "Philosophy and the Scientific Image of Man," in Sellars, *Science, Perception and Reality* (London: Routledge and Kegan Paul, 1963), 1.

[27] The order in which I individually describe these philosophical dimensions, i.e., suggestive of foundationalism (starting with metaphysical considerations and working upward to ethical considerations), is irrelevant. None of the three considerations or elements is prior to or more basic than the others.

Figure 1. The Coherence Framework



Metaphysical Considerations: A focus on such questions as, Is mental disease a freestanding entity? Is it a property? If so, what kind of property? Of what is it predicated? A Cartesian mind? An embodied person? How does mental disease compare and contrast with physical disease?

Epistemological Considerations Focuses on such questions as, How do we *know* that someone is mentally diseased? How can we reduce the incidences of "false positives" (saying someone has a mental disease when he or she does not) or "false negatives" (saying someone does not have a mental disease when he or she does)? How do we know what it is like to be the patient?

Ethical Considerations Focuses on such questions as, What is the moral status of mental disease? How should we respond morally to diagnoses of mental disease, especially if they have an unknown etiology, such as schizophrenia? Do some persons with mental diseases have a responsibility to seek treatment?

A. Metaphysical Considerations

Metaphysics aims to characterize the nature of reality, an attempt to explain how things are. So that I may develop an understanding of mental disease, the nature and existence of *mind*, along with the nature and existence of *disease*, in relation to the human *person*, are the focal metaphysical elements that will contribute to this development. In looking at these elements, independently or in association with one another, important questions are addressed, such as: What *is* mental disease? What do we mean by *mental*? What is it like to be the person with a mental disease?

In establishing what we mean by mind, disease, and person, we cannot avoid certain metaphysical considerations. The purposes of this dissertation is not to determine which metaphysical theories are the best theories in and of themselves for understanding the nature of mental disease, but to determine which metaphysical beliefs are more useful and able to cohere with the other two philosophical dimensions in the framework in order to achieve the best fit as possible. As conceptions of mind, disease, and person develop and change because of developments in scientific and philosophical thought, so will aspects of the framework as it seeks coherence among the various dimensions of mental disease.

As noted earlier, metaphysical understanding of mental disease changed as science, medicine, and philosophical thought progressed. For example, humoral theories of madness viewed mental disease as a malfunction in a system of bodily humors, characterized by an imbalance of quantity, temperature (hot/cold), or texture (wet/dry). Humoral theories of madness were replaced by mechanistic (disease as a breakdown in the mechanism of the thoughts, ideas, and/or consciousness) and ontological theories (disease as an entity, an invader of sorts, affecting one's ability to reason); these views were supported by 17th century philosophical thought involving the mind/body problem. If one were to view the mind as Descartes did - as a distinctly separate, immaterial substance - then metaphysical questions as to how the mind affects the body, and vice versa, arise, creating difficult theoretical and practical problems (e.g., how can one treat a disease, using physical or material modes of treatment [such as surgery] to change or improve the mind, when the mind is an immaterial substance?). I do not, however support a Cartesian conception of mind. It distorts the conception of person – the subject of disease. Instead of considering the Cartesian mind as the subject of mental disease, I will consider the *person* – the embodied mind – to be the subject. I examine this further in chapter 4.

B. Epistemological Considerations

Epistemology is the branch of philosophy concerned with the justification and limits of knowledge. Epistemological theories involving, but not limited to, our knowledge about mental disease and what we know about the person with a mental disease, form the second philosophical dimension of the framework. Epistemological considerations include ways clinicians attempt to discover what the patient has, what the patient is experiencing, and whether treatment is effective. How mental disease is classified and diagnosed address significant epistemological questions: How do we know what the patient has? How does the patient know he or she is mentally diseased? How do we know what it is like to be the patient? How do we know if our diagnostic systems and treatment practices are accurate? In answering this set of questions with respect to clinical classification, diagnosis and treatment, it is important to look at how clinicians know what a patient has. In this next sub-section, I look at the current classification system, written in the DSM-IV-TR and how it is used in accordance with clinical training. As demonstrated by the Soviet classification system of the mid-20th century, classifications do not always represent what mental disease is; classifications can only be used to organize and guide clinicians in diagnosing and treating what they believe to be mental disease. Not only do epistemological questions arise when looking at these classification systems but metaphysical and ethical questions arise as well, such as "What exactly is being classified?" “Should such psychological phenomena be classified as mental disease?” “Should we label a patient with a disease although his or her symptoms do not fit the classified diagnostic criteria for that disease?” In the following sub-section, I look at the DSM, a classification system clinicians use for knowing what mental disease is and for understanding what it is like to be the patient, i.e., what it is like for patients to experience a certain pattern of disturbing symptoms. The aim of the DSM, as I explain, is for *guiding* diagnostic and treatment decisions.

The DSM Classification System and Diagnosis

There is a great need for classifying mental diseases for clinical, statistical, and scientific purposes, but there has been little agreement on which diseases should be classified and how they ought to be classified. Over the years, classification systems have drastically changed; scientific and clinical data have been updated through developments in technology and in diagnostic and treatment practices, psychiatric entities and/or their definitions and descriptions have been added or eliminated from classification manuals such as the American Psychiatric Association’s DSM (e.g., homosexuality was no longer classified as a mental disorder in the DSM-III), and social, cultural, and ethical considerations are now taken into account in current systems.

However, even with all the significant changes and developments in psychiatric classification, problems still exist. The DSM is a world standard in the classification of mental disorders but not all of the criteria are clear and even the work groups, contributing their expert and diverse knowledge of disease, reject the idea that each category is a completely discrete entity with absolute boundaries.[28] The writers of the DSM-IV-TR indicate, "Although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept "mental disorder." The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations."[29]

Those in strong opposition to the classification system of the DSM, argue that mental disease cannot be classified like other diseases since there is little or no physiological evidence supporting the claim that mental disease is a physical malfunctioning of the brain. The DSM and other classification systems of mental disease may not have consistent operational definitions or may not be able to classify only those diseases that have been shown to have a kind of physical or neuropathological malfunctioning in the brain or central nervous system. The work groups that wrote DSM-IV-TR state, "The utility and credibility of DSM-IV require that it focus on its clinical, research, and educational purposes and to be supported by an extensive empirical foundation."[30] The manual is an important resource for facilitating research, improving communication among clinicians, researchers, and other health care

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[28] Gillett, 50.

[29] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision (DSM-IV-TR) (Washington, DC: American Psychiatric Association, 2000.), xxx.

[30] Ibid, xxx.

professionals, and for teaching psychopathology. In general, nosology is important for opening up communication channels between the scientific and medical communities. Some proponents of DSM suggest that because developments in clinical practice, technology, and medical research have significantly contributed to the evolution of psychiatric classification systems, there is a greater acceptance of psychiatry within the field of medicine.

Although we would like to believe that the DSM and other classification systems in psychiatry always provide accurate and reliable criteria and guidelines for treatment, this is not necessarily the case. One of the possible reasons for why criteria are often unreliable and unsubstantiated is that the system lacks a disease-specific pathogenesis on which all good diagnostic systems are based.[31] Even some of the contributors to the DSM would admit that "to determine who is 'mentally diseased' and who is 'mentally healthy', and what the nature of this 'disease' is, is a far more difficult and complicated problem than it seems, and the process through which such decisions are made is considerably less rational than traditional psychiatry would like us to believe."[32] The DSM recognizes the problem in determining who is "mentally diseased" and who is not, and thus, describes those unavoidable limitations that must be considered when diagnosing and treating patients. In order to reach a complete and accurate diagnosis, writers of the DSM suggest that the clinician must rely on his or her clinical training and judgment while using the DSM only as a guide.

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[31] Stanislav Grof,. *Beyond the Brain: Birth, Death, and Transcendence in Psychotherapy* (New York: State University of New York Press, 1985), 327.

[32] Ibid., 327.

There are two specific limitations that are illustrated in the DSM-IV-TR; (1) there is no assumption that each category of mental disorder is a completely discrete entity with fixed boundaries and (2) there is no assumption that all individuals described as having the same mental disorder are alike in every way. In a perfect classification system there would be no fuzzy boundaries and all individuals having the same disorder could be described in the same way. However, as with any classification system in medicine, the diseases and the people who have them will not always "fit" perfectly within a category or definition. For example, the patient who experiences all the symptoms of a heart attack may, in fact, not have the predicted heart failure nor even have an unhealthy heart. But since this patient 'fits the profile' of a heart attack patient, he may have to undergo unnecessary testing, thus leading to negative financial, social, emotional, and ethical consequences. It is not the case that, "a categorical approach to classification works best when all members of a diagnostic class are homogeneous, when there are clear boundaries between classes, and when the classes are mutually exclusive."[33]

Because there are no clear boundaries between classes and not all individuals described as having the same mental disorder are alike in every way, one may argue that the DSM should not attempt to be neutral about etiology. In other words, because of the lack of precise and objective criteria and the deep social, cultural, and political influential structures of the community in which psychiatry is practiced, the DSM classification system should account for all etiological variations and possibilities.

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[33] American Psychiatric Association, xxxi.

Some would also argue that diagnostic and treatment practices based on the classification system of the DSM, although attempting to be neutral in etiology, are, in fact, far from neutrality in general.

C. Ethical Considerations

Martin Benjamin and Joy Curtis write, "Ethics, understood here as a discipline whose roots go back to Socrates, is an attempt to formulate and justify systematic responses to the following question; What, *all things considered*, ought to be done in a given situation?"[34] And, in determining what ought to be done in a given situation, ethical judgments are made, indicating what is right, wrong, good, or bad. In diagnosing and treating patients with mental diseases, ethical questions arise such as: What is the moral status of mental disease? How should we respond morally to diagnoses of mental disease, especially if they have an unknown etiology, such as schizophrenia? Do persons with certain mental diseases have a responsibility to seek treatment? In this section I examine the ethical issues of patient freedom and responsibility and clinicians' obligations to accurately diagnose and effectively treat their patients. Important ethical considerations include problems of obtaining informed consent for the treatment of mental disease and problems of parentalism and involuntary commitment. In subsequent chapters I show the relationship between ethical and epistemological considerations, such in the case when a patient is no longer mentally

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[34] Benjamin and Curtis, *Ethics in Nursing*, 3rd edition, (New York: Oxford University Press, 1992.), 10.

competent to make decisions for his or herself and epistemological questions need to be addressed, e.g., "How do we *know* the person is not competent?"

Patient Autonomy and Competency

Having the freedom to make decisions is an intrinsic value. However, when a person has a mental or physical disease, sometimes making decisions about one's medical care and treatment becomes difficult. Catherine Oppenheimer writes, "...there is an intrinsic value in being able to make one's own decisions, however ill-judged they may turn out to be: none of us like to be bossed or interfered with; the sense of self-determination is something we enjoy for its own sake."[35] A person labeled as having a mental disease may experience a loss of freedom by willingly or unwillingly giving up the right to make medical decisions. Oppenheimer indicates that giving up this right may involve the patient asking a clinician and/or family member to make a decision. A decision may be made automatically if the patient is physically or mentally incapable of making or communicating a decision, or the patient may be judged by others to be incapable of making a decision.[36] Oppenheimer writes, "The last of these three possibilities is the one where tension between self-determination and determination by others is most apparent. It acknowledges that there are situations in which a person's clearly spoken intentions and wishes concerning his or her own life can be invalidated or discounted by others."[37] The issue of when to restrict freedom is extremely

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[35] Catherine Openheimer, , "Ethics in old age psychiatry" in *Psychiatric Ethics*, 3rd edition, edited by Sidney Bloch, Paul Chodoff, Stephen A. Green. (New York: Oxford University Press, 1999), 320.

[36] Ibid., 320.

[37] Ibid., 320.

important in psychiatric medicine. Looking at issues such as compulsory hospitalization raise several important ethical questions, such as "Should we restrict the autonomy of a person when he or she no longer has the capacity to make decisions?" "If so, on what grounds?" "Who should make such a decision?" "If the patient were competent, would he or she make this decision?" "Does this decision cohere with the patient's values?" These ethical questions also involve epistemological considerations. For example, before we can ask whether we can restrict the autonomy of an incapacitated person, we need to first ask ourselves, "How do we *know* when someone is incapacitated to make autonomous decisions?"

Forcing treatment and hospitalization may help a mentally diseased patient when he or she really needs help, but the decision, made by another, violates the patient's self-determination. While forced treatment and hospitalization is lawful if the patient whose disease prevents him or her to make a rational decision, and "the risks of not deciding are sufficiently grave"[38], it is not entirely clear when decisions should be made on the behalf of patients. For one, it is not always clear when a patient really needs to be hospitalized rather than receiving outpatient care. Second, caregivers may have different interpretations as to what is or is not a "rational decision". Third, determining whether the risks of not deciding are sufficiently grave may also involve different interpretations.

Oppenheimer explains the psychiatric assessment of patients' decision-making capacity or competency can be seen as a "graded and variable attribute of the person,

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[38] Ibid., 326.

rather than as something either present or absent."[39] However, from a legal standpoint, an absolute decision needs to be made. Oppenheimer writes, "The clinician is expected to judge capacity *in relation to the specific decision that has to be made*, and she will decide whether the abilities that she is assessing have crossed a threshold appropriate to that decision."[40] Although a clinical judgment has to be made, it must be understood that judging patients' decision-making capacity does not rest on precise criteria. Clinicians draw upon their own experiences and judgments, especially in judging if the patient has difficulty predicting possible future consequences or outcomes, which is part of the process of arriving at a decision. Oppenheimer states that we must accept that judgments about patients' decision-making capacity should be made in relation to a specific decision, but we must also understand that such judgments are ultimately subjective, even when general guidelines and particular tests are used.[41]

Clinical Diagnosis

Reich writes, "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."[42] Reich explains that misdiagnosis can occur

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[39] Ibid., 326.

[40] Ibid., 326.

[41] Ibid., 328.

[42] Walter Reich, "Psychiatric diagnosis an ethical problem" in *Psychiatric Ethics*, 3rd edition, edited by Sidney Bloch, Paul Chodoff, Stephen A. Green (New York: Oxford University Press, 1999), 193.

in two ways. The first way is *purposeful*, where the clinician applies a standard diagnosis to a patient "for whom he or she knows it to be inappropriate in order to achieve some end that is not, by common definition, medical."[43] Clinicians may issue a purposeful misdiagnosis at the patient's request or at the request of another. For example, a family member may pressure the clinician to institutionalize a disturbed loved one, or a patient may want to be institutionalized as a way to avoid the military draft. For whatever reasons patients and others may have for a purposeful misdiagnosis, these reasons are clearly unethical, since the diagnosis is intended for some end other than meeting the clinical needs of the patient.

The second way a misdiagnosis can occur is through *non-purposeful* causes. This way, Reich believes, deserves the greatest scrutiny because most misdiagnoses are non-purposeful and are not as clearly unethical as purposeful ones.[44] Non-purposeful misdiagnoses are different from mistakes. Mistakes, according to Reich, are the result of inadequate information about the patient and his or her disease and/or a lack of training; the clinician "issues a diagnosis to a person whose clinical state should be categorized differently."[45] A non-purposeful misdiagnosis, on the other hand, is when a clinician gives an incorrect diagnosis due to factors extrinsic to the patient without being aware, even though the clinician has adequate knowledge and training.[46] Reich explains non-purposeful misdiagnoses can be traced to three sources.

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[43] Ibid., 194.

[44] Ibid., 194.

[45] Ibid., 195.

[46] Ibid., 195.

The first source is the vulnerability of diagnostic error. Reich states that the diagnostic process has poor reliability, may be inconsistent, often suffers from bias, and may rely on subjective criteria, among other associated problems. This is an ethical concern because, although classification systems have made it easier for clinicians to reduce diagnostic errors, the clinician must be responsible for understanding the limitations of these systems as well as his or her diagnostic judgments. Without acknowledging these limitations responsibly, non-purposeful misdiagnosis may occur. Reich writes, "At least, psychiatrists are no better than their tools; and they must acknowledge the limitations of those tools as the starting points of their own."[47]

The second source of non-purposeful misdiagnosis involves the diagnostic theory itself. Reich explains that clinicians rely on one or more theories of mental disease, some of which are associated with diagnostic systems such as the DSM. Reich states,

> And, depending on the specificity of the system to which he or she subscribes, the ways in which a psychiatrist assesses a person's behavior, draws conclusions about it, weighs the variance between the person and the social norm – indeed, *sees* the person – may be heavily influenced by the assumptions underlying the system and the approach that system takes to recognizing and identifying mental illness. The system, after all, delineates categories of illness and

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[47] Ibid., 196.

> identifies the criteria by which behaviours and the persons who exhibit them deserve to be placed in those categories; and every time such a placement is made the categories, as well as the system itself, are reified.[48]

If the system to which the clinician subscribes is believed to involve criteria too narrow or too broad to base a diagnosis on, Reich suggests the reification of the categories and the system itself may be false, resulting in systematic, non-purposeful misdiagnoses.

The third source of non-purposeful misdiagnoses is the beauty or attractiveness of the diagnostic process as a way to solve (or avoid) human problems. The attractiveness of the diagnostic process can be viewed in several ways. For one, diagnosis can provide an explanation, suggesting to the patient that the medical problem is understood by clinician. Reich suggests, however, there is the temptation to provide an explanation even when the disease does not exist or is marginally present. Another way in which diagnosis appears attractive is its "power to reclassify whole categories of socially unacceptable behavior as the products of psychiatrically diagnosable conditions."[49] One example is homosexuality. Previously viewed as an immoral, sexual deviancy, homosexuality became reclassified as a disease, rather than a socially unacceptable behavior. However, under this reclassification, homosexual individuals were forcibly treated through pharmacological and surgical means, which were neither

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[48] Ibid., 196-7.

[49] Ibid., 209.

effective nor humane. Eventually homosexuality was eliminated from diagnostic systems and reclassified as a sexual preference rather than a disease. Although reclassification may be beneficial for some conditions, it can be ethically problematic in some situations, especially when the "socially unacceptable behavior" is not completely understood.

Although diagnosis can be useful in many ways, such as helping clinicians and patients understand and consistently recognize patterns of symptoms, it can be ethically and socially problematic in many ways clinicians need to be aware of. Reich explains that diagnoses can harmfully label, exclude, and dehuminize patients. Reich writes, "Informally, the terms 'crazy', 'mad', and even 'schizophrenic' often serve as exclusionary labels that are used in everyday language to identify others who are annoying, discomfiting, and different. Formally applied – that is by psychiatrists – diagnoses can make a person into someone who seems wholly other, and who *requires* exclusion."[50] The writers of the DSM acknowledge the harmful nature of labels and advise clinicians to refer to patients not as the "schizophrenic", for example, but "the person with schizophrenia."[51] Emphasizing that what are being treated are persons and not disease entities is an important ethical consideration.

In order to reduce or eliminate the possibilities for unethical diagnostic practices, clinicians must not only recognize the ways in which purposeful misdiagnoses can occur, but also the ways in which non-purposeful misdiagnosis can occur. And although safeguards have been implemented to some extent, such as the

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[50] Ibid., 211-12.

[51] American Psychiatric Association, xxxi.

development of diagnostic systems to improve accuracy and credibility of diagnosis, clinicians need to understand the potential problems employed by these safeguards.

Psychiatric Treatment

Although there are several types of treatment, in this section I focus on two treatment practices: psychotherapy and somatic treatment (e.g., drug therapy). Most treatments in psychiatry aim to alleviate pain or discomfort, such as antidepressant treatment. Jeremy Holmes writes that psychotherapy works differently where the focus is on the enhancement of autonomy based on self-knowledge.[52] Holmes writes, "...psychotherapy offers autonomy – with its implications of wholeness, individuation, and freedom of choice – rather than absence of pain, or indeed the illusory search for happiness, as *the* goal worth striving for."[53] One of the purposes of psychotherapy is to encourage patients to experience the emotions they repress, deny, or avoid and to eventually get to the point where they are able to feel in control of their own lives. In encouraging patients to express hidden emotions and to have more autonomy in their lives, Holmes states that ethics impacts on psychotherapy in several ways. The first ways involves the interaction between therapy and the real world. Holmes writes, "Therapists should respect the need for informed consent, and the therapeutic contract, and justify their handling of these issues with patients. Equally it is essential that practitioners understand the nature of and need for boundaries – especially in relation to

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[52] Jeremy Holmes, "Ethical Aspects of the Psychotherapies", *Psychiatric Ethics*, 3rd edition, Sidney Bloch, Paul Chodoff, Stephen A. Green (eds.) (New York: Oxford University Press, 1999.), 229.

[53] Ibid., 235.

confidentiality and sexual transgression."[54] Therefore, it is important to establish a therapeutic relationship between therapists and patients where needs are clearly and openly expressed by the patient and met (or at least understood) by the therapist through open communication channels, involving respectful and truthful discourse.

The second way ethics impacts psychotherapeutic practice is the recognition of values, which operate as "unexamined basic assumptions influencing practice just as many of our choices and preferences are unconsciously determined."[55] Becoming aware of these values is an important aspect of being an ethically responsible clinician; without this awareness, the patient is not respected as a whole person. Being aware of a patient's values not only enhances the therapeutic relationship, but also makes treatment goals more attainable.

The third way involves the developing and following of ethical guidelines and regulations geared specifically for psychotherapeutic practices. Holmes explains that ethical codes of practice are used to express the responsibility of clinicians to match therapy to patient need, respect confidentiality, not to exploit patients, and so forth. Developing regulations not only benefits patients and the public, but also has "a self-serving aspect in lending respectability to the profession."[56]

Although most of the ethical considerations do not differ between psychotherapy and other methods of treatment, respecting patient autonomy is one of the main goals of psychotherapy and cannot be achieved without a strong therapeutic relationship.

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[54] Ibid., 225.

[55] Ibid., 225.

[56] Ibid., 241.

Without this relationship, the patient is unable to express hidden emotions and thoughts and the clinician is unable to be a proper guide in helping patients regain control over their lives. However, there are several pitfalls to psychotherapy. For one, psychotherapy is not useful when patients with severe psychological and physical problems are unable to understand and communicate their needs to the clinician. Second, it is not useful when clinicians use psychotherapy without considering other methods of treatment, which may or may not be more useful. Third, patients may become dependent on psychotherapy, finding comfort in *getting* treatment rather than in what the treatment has to offer. Besides recognizing these pitfalls, clinicians may have to provide other methods of treatment, such as drug therapy.

Neil Scheurich claims, "When a clinician chooses between somatic treatment (or any behavior intervention in other areas of medicine), and she is mindful of the moral dimensions of care, then she will opt for somatic treatment only when she believes that the patient does not possess the self-governance for healing through reflection, deliberation, and action alone."[57] However, Scheurich also claims there are many situations in which somatic treatments ought to be primarily considered, since they increase the capacity for autonomy by eliminating or alleviating symptoms. He writes, "Somatic treatment can be highly empowering, liberating a will too impaired or cowed to be awakened by persuasion or enlightenment alone."[58] Nevertheless, as Scheurich and others have pointed out, there are ethical concerns involving the use of somatic

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[57] Neil Scheurich, "Moral Attitudes and Mental Disorders" *Hastings Center Report*, 32, no. 2, (March-April 2002), 19.

[58] Ibid., 19.

treatments, namely pscyhopharmacological treatments, or drug therapy. For one, patients using drugs to alleviate symptoms of mental disease may "not feel like themselves", or as Scheurich states, "obstruct an individual's authenticity".[59] For example, many of the psychotropic drugs used by patients with schizophrenia cause disturbing side effects. As a result, patients either refuse these drugs or do not take them as prescribed, and, in effect, patients do not receive the needed treatment. Also, Scheurich implies that when clinicians focus on the mechanisms of the brain, i.e., manipulating neurochemicals in the brain through psychotropic drugs, patients are viewed as mere machines with somatic experiences, which can be empirically explained. However, patients are not machines, but persons, with somatic, or physical, and psychosocial experiences. The patient must be viewed as a person – an embodied mind.[60] And, As Scheurich writes, "A clinician ought to be more than a biological technician, more even than a "compassion machine"; a clinician ought to assist a person's inquiry into and quest for a better life."[61]

In order to understand the conceptual problems associated with understanding mental disease, a better, general understanding of disease is necessary. In the next chapter, I investigate normative and non-normative conceptions of disease and construct a general understanding based on these conceptions with respect to clinical and philosophical considerations. I conclude that both normative and non-normative conceptions are significant for developing a better understanding of disease.

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[59] Ibid.,19.

[60] This concept will be explained with greater detail in chapter 4, *The Diseased Embodied Mind.*

[61] Ibid.,20.

CHAPTER 3

A CONCEPTUAL INVESTIGATION OF DISEASE: CONSTRUCTING A GENERAL UNDERSTANDING

Introduction

In the previous chapter I described the problem at hand - that because we do not have a better conception of mental disease, we are unable to accurately define, classify, diagnose, and treat particular mental diseases, often resulting in negative consequences such as stigmatization. In working through this problem, trying to understand why we do not have a better conception of mental disease, and why this conception has not been soundly instituted into our systems of classification and our medical models of diagnostic and treatment practices, a framework is required. This framework must be designed to connect the metaphysical, epistemological, and ethical elements that address the pertinent questions surrounding the nature of mental disease, including those who are mentally diseased. The aim of this framework is to acquire a better understanding of mental disease, as well as to provide possible solutions to those metaphysical, epistemological, and ethical problems affecting those who are diseased and those persons who study, classify, diagnose, and treat disease.

This chapter provides background into our understanding of health and disease in general. I first describe the concept of disease from normative and non-normative perspectives. I then propose that both perspectives are essential for understanding the concept of disease. The purpose of this chapter is not only to become clearer on what disease is, but also to prepare the ground for looking at disease through a coherentist

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framework, from which I draw significant conclusions as to how we ought eventually to construct a more comprehensive notion of mental disease in subsequent chapters.

This chapter is divided into four sections. The first briefly illustrates the problems in defining the concepts of health and disease, and why most definitions are inadequate. Understanding the concepts of health and disease and the philosophical problems surrounding such concepts would involve a lengthy critique. The purpose of this section, and this chapter for that matter, is merely to introduce the controversial concept of disease in preparation for the next chapter, as the issues greatly increase in complexity and richness when we move from disease in general to mental disease more specifically.

In the second section, I describe Christopher Boorse's well-known non-normative concept of disease. Boorse defines disease, or what he refers to as statistically species-atypical functioning, from a non-normative perspective, rather than from normative perspectives. He believes that clinical concepts of disease do not give us a proper understanding. Disease, for Boorse, is basically a value-free, pathological concept.[1]

One reason to define disease from a non-normative, or value-free, perspective is to standardize the concepts of health and disease. If we were to define and understand health and disease merely as normative concepts, the values we place on such concepts would not be universally applicable due to the variability of values attributed to these concepts by a particular individual or group in a given context or situation. Part of our understanding of health and disease includes understanding their significance and use, but

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[1] Introduction to Christopher Boorse's article on "A Rebuttle on Health" in *Biomedical Ethics Reviews: What is Disease?*, James M. Humber and Robert F. Almeder (eds.) (New Jersey: Humana Press, 1997.), 1.

we cannot understand why these concepts are significant or why we place value on them without first determining what they essentially are.

In the third section I contrast Boorse's approach with a conception of disease as a normative, or value-laden, concept. Normativists believe a purely value-free concept of disease is insufficient for understanding not only what disease is, but also what disease means for the individual who has a disease, and for those who study, diagnose, and treat it. They suggest disease is, wholly or in part, a normative concept. Proponents of this view, such as Caroline Whitbeck, contend that "to characterize something as a disease is therefore to appeal to certain norms or values; it is to make a value judgment of some kind about a physical condition."[2] For example, without patients' reports of their subjective experiences of 'abnormal functioning' and clinician involvement in detecting, classifying, diagnosing, and treating disease, it is suggested that we have an incomplete picture of what disease is and what it means to have a disease. In this section, I focus on the work of H. Tristam Englehardt, who believes disease is both a descriptive and an evaluative concept, where the norms and values placed on disease and those who are diseased, are especially significant in clinical practice. In this section I also look at the notion of illness. Illness, as some would claim, focuses on the subjective experiences of the person having related or unrelated symptoms of disease. One could experience pain and discomfort in the abdomen, for example, without having a disease. In this case, we would say this person is ill, but not diseased.

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[2] W. Miller Brown, "On Defining 'Disease'." *Journal of Medicine and Philosophy* 10, (1985), 320.

In the fourth and final section, I show that *both* Boorse's value-free and Englehardt's value-laden theories contribute to a better understanding of disease. I then propose a different conception of disease, one that is applicable to any context or situation. Unlike Boorse's project, which separates non-normative, or what he refers to as theoretical, from clinical levels of disease, my coherentist conception of disease will not discriminate among levels of disease. Instead of merely taking a middle position between value-free and value-laden concepts of disease, I am considering both concepts by bringing them into a coherentist framework with other metaphysical, epistemological, and ethical elements; and, in working back and forth between each element, making adjustments along the way, a more richly textured concept of disease will arise.

Disease: A Controversial Concept

The contestable definitions of health and disease foster the various problems surrounding mental disease as it is defined, characterized, and understood as an entity related to, but not entirely consistent with, the general notion of disease. In the following chapter, my goal is to develop a more richly textured, useful understanding of mental disease. However, before this can be achieved, the concept of disease, in general, and the controversies surrounding this concept, must be addressed.

In trying to conceptualize the notions of health and disease several definitions have been proposed, most of which have failed in providing a cogent and comprehensive account of their significance and use. Definitions of health and disease, and related concepts such as illness, are often criticized for being too vague or inconsistent with what we know about medicine, society, and specifically the human mind and body.

Philosopher W. Miller Brown writes “the difficulties with understanding concepts of health and disease are not due to serious problems with medicine; rather, they derive from the concepts themselves, their vagueness, complexity, and richness of cultural and historical associations.”[3]

One such vague definition of health is defined by the World Health Organization (WHO). WHO defines health as “a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity.”[4] This definition is unclear in that it does not indicate what it means to have *complete* physical, mental, and social well being. Furthermore, this definition of health uses general concepts such as “well being” and “disease” without explicating their meaning. Daniel Callahan writes, “one common objection to the WHO definition, is, in effect, an assault upon any and all attempts to specify the meaning of very general concepts. Who can possibly define words as vague as “health”, a venture as foolish as trying to define “peace,” “justice,” “happiness,” and other systematically ambiguous notions.”[5]

So why are the concepts of health and disease so unclear with an array of meanings and uses? Part of the difficulty is attributable to the way we value health and disvalue disease. We tend to believe that health is good, something that is to be desired, and disease is bad, or something that is harmful and needs to be eliminated from existence. Some believe the notions of health and disease should not be viewed as conceptual opposites, especially since the concept of disease is not and should not

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[3] Brown, 323.

[4] Daniel Callahan, “The WHO Definition of Health.” *Hastings Center Report*, 1, no. 3 (1973), 77.

[5] Callahan, 77.

consistently be viewed negatively. Diseases do not always impair or threaten health. Some diseases are unpleasant and disabling but do not compromise the health of the individual who has them. For example, withstanding a short bout of the measles during childhood, either through infection or inoculation, may actually be conducive to health.[6] Although we should not always view disease negatively, in reality, the public consensus is that disease is something bad, and people who are diagnosed with a disease are often labeled or categorized as such, creating social stigmas that are deleterious to the individual. Philosopher Arthur Caplan suggests the disease label may even excuse those behaviors that are considered to be criminal, sinful, or both.[7] By excusing certain behaviors, people are not held responsible for their actions. are often pitied, and are unable to get help when it is needed[8]. Caplan writes, "Disease labels, while often exculpatory in terms of liability or responsibility, carry other burdens such as the stigma attached to illness and the assumption that those who are ill or diseased require treatment and cure from legitimate experts."[9]

Besides controversies over the values we place on the concepts of health and disease, further dilemmas arise in determining the nature of disease, and how it ought to be defined, described, and understood. Historically disease has been a highly controversial concept due to its varied characterizations. Whether disease was primarily

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[6] Arthur L Caplan, "The Concepts of Health and Disease." *Medical Ethics*, edited by Robert M. Veatch. (Boston: Jones and Bartlett Publishers, 1989), 55.

[7] Caplan, 55.

[8] When certain behaviors are excused, the individual in need of help is often unable to recognize this need under the assumption that excused behaviors do not necessitate modification, treatment, or even acknowledgment.

[9] Caplan, 55.

thought of as an imbalance in Hippocratic humoral medicine, a disease entity invading the host body, or a set of biophysiological, psychological, and social phenomena, there have always been disputes over whether disease was relational and contextual in character, or a substantial thing(s).[10] In talking about this highly controversial concept, Englehardt looks at two theories: the ontological and the physiological theories of disease. The ontological theory of disease involves looking at disease as a specific entity or looking at the cluster of signs and symptoms forming the character of a disease. Caplan writes, "In ontological theories, these characteristic disease patterns are interpreted as enduring disease types often without an immediate connection to a particular theory of material disease entities."[11]

Opposing the ontological theories of disease is the physiological or functional way of looking at disease. Englehardt illustrates three points given by those arguing for a physiological concept of disease. First, the concept of disease should be a general and not a specific notion, where disease functions are of the general laws of physiology rather than the particular laws of the pathology of specific diseases. Second, there ought to be "a greater appreciation of the individuality of illnesses so that every particular disease-state could be understood in terms of its particular departures from general physiological norms."[12] Third, there is a need to avoid the metaphysical and logical problems associated with ontological concepts of disease; diseases are contextual and not merely

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[10] Tristram Englehardt, "The Concepts of Health and Disease", in *Concepts of Health and Disease Interdisciplinary Perspectives*, Arthur L. Caplan, H. Tristam Engelhardt, Jr., James J. McCartney (eds.) (Reading, Mass: Addison-Wesley, Advanced Book Program/World Science Division, 1981.), 33.

[11] Ibid., 35.

[12] Ibid., 36.

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[13] Ibid., 36.

[14] Ibid., 43.

things. To reiterate the major differences between the ontological and physiological concepts of disease, Englehardt writes,

> Ontological theorists framed views within which diseases could be appreciated as specific entities. Physiological theorists framed views within which diseases could be appreciated as particular deviations from general regularities. In the first case, the accent of reality fell upon the disease; in the second case the accent fell upon the individual and his circumstances, including the laws of physiology.[13]

I return to Englehardt's theory of disease in the third section. Englehardt rejects the ontological theory of disease by viewing disease as "a mode of analyzing phenomena for the purposes of diagnosis, prognosis, and therapy", rather than a specific entity or thing.[14] Christopher Boorse supports a physiological theory of disease, also rejecting the ontological theory of disease, and views disease as a deviation from statistical species-typical functioning. Boorse's theory affirms the need to understand disease free of values before considering why and which values are placed on this controversial and vague concept. We cannot begin to understand why we place values on disease, be they negative or positive, or whether we ought to, until we have an understanding of this

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[13] Ibid., 36.

[14] Ibid., 43.

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concept at the most basic, value-free level. Furthermore, we are unable to formulate a better understanding of *mental* disease without investigating the nature of disease, in general, as it is conceptualized from a non-normative perspective. In the end, I will conclude that we cannot fully understand mental disease, or even somatic disease for that matter, without looking at the values we place on such concepts. Disease is not separate from the subjective experiences of the embodied person. Disease affects, either positively or negatively, the person holding certain values and beliefs about the phenomenon of disease, including its causes and patterns of symptoms, and how it ought to be classified, diagnosed, and treated. One may argue, as does Boorse, that the values we place on mental disease are more controversial than those values we place on somatic disease, since mental disease is something mysteriously distinct and separable from, and unexplainable by, somatic diseases. Boorse explains,

> The influence of values on health judgments has usually seemed most potent in the area of mental health. This is one reason why so much work on the topic is by psychiatrists and psychologists and tends to ignore physical counterparts to the issues it discusses. By contrast with somatic medicine, it is felt, ordinary mental-health practice involves very controversial value commitments, which surface when one deals with any of a whole spectrum of

> social causes celebres from criminal insanity to
> homosexuality and feminism.[15]

If a clearer picture can be drawn as to what disease is, as a broad concept encompassing both somatic and mental diseases from both normative and non-normative perspectives, mental disease would appear to be more closely related to somatic diseases (and vice versa), suggesting that mental disease is not so mysterious or indiscernible. By looking at disease as a general concept, which covers somatic and mental diseases, we will be able to determine the significant similarities between these two, more specific, conceptions of disease.

A Value-free Conception of Disease

The concept of disease is, according to Christopher Boorse, often misrepresented and misunderstood because of its affiliation with medical practice under the assumption that "to be a disease is to be the sort of thing doctors (ought to) treat."[16]. Boorse's project aims to distinguish the general, value-free concept of disease from how it is understood in clinical practice, or from what is entailed by therapeutic judgments regarding the need for medical treatment.[17] He claims that the desirability or undesirability of physical conditions and the need to treat such conditions does not make them diseases, e.g., conditions that restrict a person's physical well being, such as below-average strength or

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[15] Boorse, "Health as a Theoretical Concept" *Philosophy of Science*, 44 (1977), 543.

[16] Ibid., 544.

[17] Ibid., 544.

beauty. Boorse states, "Treatment in medical practice is neither necessary nor sufficient for something to be a disease."[18] And, instead of supporting a clinical definition of disease, Boorse poses a much broader notion, one that extends outside of the medical field, and even beyond the notion of *disease entity*.[19] Boorse points out some conditions such as diarrhea are not accepted as specific diseases in medicine. These conditions are common to many types of diseases, but are not themselves diseases in the strictest sense of the word, meaning that they are not listed or categorized as such in medical literature.

Boorse believes it is not the task of the medical community, but the task of empirical science to devise theories that describe and explain both the normal bodily processes and states and also those deviations from them, which are the primary features of disease. Besides defining disease as concept extending beyond the medical field, he defines disease as a concept that is value-free, one that is stripped of any values, including those values set by the medical community in their determination of which diseases ought to be categorized as such.

Boorse, in viewing health as a non-normative, or value-free, concept, suggests that health is a statistical normality of function, i.e. an ability to perform all typical physiological functions with at least typical efficiency. Health is the absence of disease and disease, Boorse defines, is "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

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[18] Ibid., 546.

[19] The term *disease entity*, a constellation of signs, symptoms, and pathology with specific etiology and prognosis in today's strictest definition, Boorse writes, is not always listed in medical sources, which is suggestive of how disease is often misrepresented.[19] (Boorse, "Health as a Theoretical Concept," 552) Disease entity is often considered a specific, natural thing, which invades and destroys or impairs the body.

efficiency, or a limitation on functional ability caused by environmental agents."[20] This is what Boorse refers to as his biostatistical theory (BST) of disease. According to Boorse's BST, an organism is healthy if and only if it is functioning (at or above the statistically normal level of functioning) for organisms of that type.[21] This is how disease can be understood at the most basic level without appealing to certain norms or values. By understanding disease from a non-normative perspective, we are able to determine what constitutes as a disease and what does not, regardless of whether the concept of disease makes sense according to our everyday language usage. For example, we would not typically say that a man with poor vision and requiring eyeglasses is *diseased.* However, poor vision suggests impairment of normal functional ability, which, according to Boorse, is a disease, regardless of the fact the man can wear corrective eyewear. By understanding the concept of disease in this way, we are able to determine when and possibly why individuals are diseased prior to attributing meaning or changing the way we talk about the disease in question.

According to Boorse, the only relevant functions for determining when a human is healthy or diseased are physiological functions, or those functions that contribute to goals of reproduction and survival.[22] In determining which functions are atypical or typical for a given organism, Boorse believes that it is only the subfield of physiology whose

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[20] Boorse, "A Rebuttal on Health", 7- 8.

[21] The BST includes plants, non-human animal, and human organisms. For our purposes, I will just be considering human organisms.

[22] Boorse's account excludes structural diseases such as minor deformities, or those deformities that do not disturb normal function. Major deformities, on the other hand, involve deviations from functional normality. He believes that "no correct account can make structural deviation a sufficient condition of disease." (Boorse, "Health as a Theoretical Concept," 565)

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functions seem relevant to health (different subfields of biology, e.g., genetics, have different goals), since these functions specifically contribute to individual survival and reproduction.

The structure of organisms shows a means-end hierarchy with goal-directedness at every level. Boorse indicates, "Organisms are goal-directed or disposed to adjust their behavior to environmental change in ways to a constant result, the goal."[23] For example, goals such as muscle contractions contribute to behavior such as prey catching, which in turn, contribute to the higher goals of reproduction and survival.[24] When an organism has a malfunction or an atypical function, the result may be an inability to reach such goals, which directly or indirectly contribute to the higher goals for reproduction and survival. For example, if a person's pancreas fails to produce insulin, i.e., has the chronic, incurable disease known as diabetes, without adequate treatment, further complications such as coronary artery impairment, visual system impairment, and autonomic nervous system impairment, just to name a few, can develop. The diabetes disease compromises the ability to achieve certain goals, including those higher goals of reproduction and

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[23] Ibid., 555-6.

[24] One may point out that in Boorse's analysis the higher level goals of organisms are indeterminate and must be determined by a biologist's interests. And, if the interests of the biologist must determine higher level goals, this suggests a normative component to Boorse's concept of disease. Some critics have suggested these higher level goals of cognitive functioning organisms (humans) are essentially normative in that we may have a preference as to how we achieve the goals of survival and reproduction, especially if there are multiple ways in achieving these higher goals. Boorse argues that all organisms including human beings are the product of a long course of biological evolution, which is a process that has been driven by a wide variety of environmental demands. He believes health consists in the functioning of any organism in conformity with its natural design, as determined by natural selection. It is the biologists' interests to provide a descriptive account of how and why the functioning of organisms is determined by natural selection. "To choose wood over concrete to build your house with is an evaluative choice, but that does not make the concepts of wood and concrete value-laden." (Boorse, "A Rebuttal on Health", 27.)

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survival, since the activities and functions of the individual are limited and there is the possibility for further life-threatening complications.

One important aspect of Boorse's non-normative concept of disease is its ability to provide an empirical measure of what functions are typical or normal to a given reference class. The *reference class* is a natural class of organisms of uniform functional design, specifically, an age group of a sex of species. For example, reproductive functions of women between the ages of 25 and 35 are empirically measured to determine if such functions are normal or typical. This is what Boorse refers to as *statistical normality*. Because there seems to be some variability of health and disease based on a species' age and sex, the notion of a reference class is an important consideration even for normative concepts of health. Some diseases may be variable among a species' age, sex, or even race. For example, only males can get prostate cancer; females do not possess this organ, and therefore cannot get cancer of the prostate. This is what Boorse means by variable among a species' age, sex, or race.

However, not all diseases are variable among a species' age, sex, and/or race. There are some universal conditions, or those diseases that are typical of the whole population, such as dental caries. Boorse suggests some of these universal conditions are, in fact, diseases, although the majority of people may have these conditions, suggesting a statistical functional norm. Boorse states, "Unless there are specific body locations which are typically carious or atheromatous, these conditions are diseases on our account. The universal diseases which violate the definition seem to be those which are evenly distributed, e.g., lung irritation due to environmental pollution or arterial thickening after a certa

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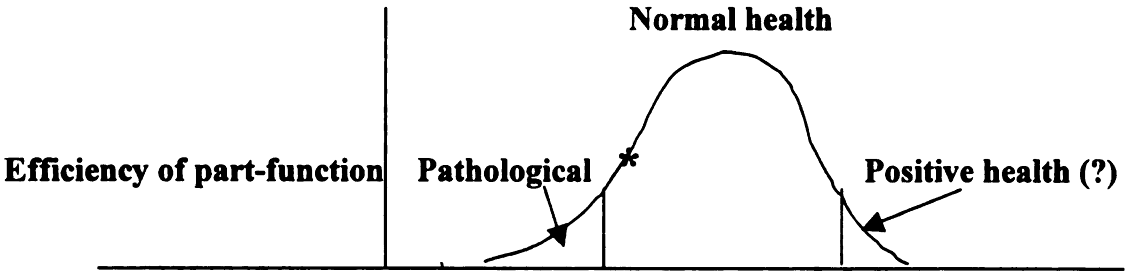
a certain age."[25] In general, deficiencies in the functional efficiency of the body are diseases when they are unnatural, and they may be unnatural either by being atypical or by being attributable mainly to the action of a hostile environment.[26]

To sum up Boorse's value-free concept of disease, the following diagram, resembling the one used by Boorse, will be used. This diagram is used to explain Boorse's normal-pathological distinction, which depends on three concepts I have already briefly outlined. These concepts include the reference class, statistical normality, and biological functions. Although this diagram is useful for understanding Boorse's BST, some aspects of this diagram are unclear and require further analysis. I will only identify these unclarities and leave the analysis for another day.

Figure 2. Statistical distribution in reference class[27]



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[25] Boorse, "Health as a Theoretical Concept", 566.

[26] Boorse, "On the Distinction between Disease and Illness." *Philosophy and Public Affairs* 5, no. 1, (Autumn 1975), 59.

[27] Based on Boorse's graph titled "Pathological-Normal Distinction" in his article "A Rebuttal on Health", page 8.

First, under Boorse's definition, one could possibly have positive health, such as above-average intelligence, but the idea of positive health can be a vague concept when imagining some functions exceeding normal capacities (e.g., a heart or kidney functioning above normal or typical). This is why I suppose Boorse placed a question mark at this point on the graph. However, my concern is not that positive health is or is not a legitimate concept. My concern is at the point where normal health either becomes pathological or positive. Upon viewing this diagram one could have slightly below-average health, near, but not *at* the pathological state, as indicated by the star I have placed on this diagram. How do we determine whether this point accurately represents normal or abnormal functioning? Statistically speaking, the star is in the area of normal health, but in reality, this star represents a person (and not a statistic) who may be viewed as diseased because s/he is close to what may be perceived as pathological. This concern is one in which a normative conception of disease can address and possibly provide a useful solution to this statistical quandary.

A Normative Conception of Disease

Some philosophers reject the belief that disease is a value –free concept, as suggested by Boorse. These philosophers, known as normativists, believe the concepts of health and disease cannot be defined without reference to values. As Arthur Caplan puts it, "Health and disease are inherently value laden, and to fully understand these concepts, one must realize that decisions about the status of the mind or body involve considerations of what is good, bad, desirable, or undesirable."[28] Some philosophers in

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[28] Caplan, 50.

the normativist camp may view health judgments to be pure evaluations without descriptive meaning. This is what Boorse refers to as strong normativism. Others may not view health and disease as strictly normative but normative in a weak sense (weak normativism). Weak normativism suggests that judgments about health and disease have a descriptive as well as a normative component.[29] One such (weak) normativist, H. Tristam Englehardt, believes the concept of disease is both evaluative (normative) and descriptive (non-normative), and supports a clinical approach for defining disease, since a properly understood concept of disease is critical for taxonomy, diagnosis, and treatment purposes.

Englehardt, like other normativists who focus on a clinical definition of disease, believes that what we do not know about disease and its relationship to people becomes clearer based on the subjective experiences of the patient and the interests of those detecting, classifying, diagnosing, and treating disease. (1) By experiencing and reporting symptoms, e.g., pain, (2) having the knowledge that one has a disease, i.e., information acquired through clinical diagnosis, and (3) determining what ought to be done, if anything, if a disease has been diagnosed, the concept of disease no longer remains free of values. In acquiring information about the disease, e.g., the pattern of symptoms that may characterize the disease and ways to treat the symptoms and/or the disease, the patient concurrently develops an interest in the disease. The healthcare professional also has an interest in the disease and how the disease negatively or

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[29] Boorse's own position may arguably be normativist in the weak sense, as some critics have pointed out, but his position clearly demonstrates that strong normativism is an insufficient theory of health and disease.

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positively affects the patient. Although the interests can differ between patient and healthcare professional, some interests may overlap, such as the desire to treat disease.

Englehardt suggests the concept of disease is a way to explain, predict, and control dimensions of the human condition; it may be "a basically heterogeneous concept standing for a set of phenomena collected together out of diverse social interests, not on the basis of the recognition of a natural type or a common conceptual structure."[30] Englehardt explains how disease, as a normative conception, incorporates criteria of evaluation, whereby states of affairs are deemed desirable or undesirable. Furthermore, as a normative concept, disease "delineates and establishes social roles such as being sick or being a physician", and it "interconnects these roles with a network of expectations structured by rights and duties."[31]

Englehardt suggests disease is multidimensional, involving patterns of causes, and correlated with signs and symptoms. But disease is not merely an entity, a phenomenon with symptoms, signs, and causes. Englehardt claims that disease is an explanatory account bound to the experiences of that account. "Explanatory accounts are not things; things are what explanatory accounts explain and disease is a mode for explaining things-in particular, ill humans."[32] The concept of disease is a mode of analyzing and explaining certain phenomena for the purposes of diagnosis, prognosis, and therapy.[33]

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[30] Englehardt, 32.

[31] Ibid., 33.

[32] Ibid., 40.

[33] Ibid., 43.

In looking at Boorse's BST, Englehardt does not believe that disease is unique only to a particular species' age and sex (the reference class). He argues against Boorse's non-normative theory of disease, stating that Boorse does not fully consider intraspecies variability in his BST; "what will count as successful function in one environment may count as disease in another."[34] Englehardt writes,

> To decide what is a problem for medicine, one must make reference to a particular environment and a particular set of goals, so that one can understand whether the individual is well adapted. What will be required for the realization of particular goals will differ from environment to environment. If one is a black living in Trondheim without the availability of exogenous vitamin D, then the possession of highly pigmented skin would put one at a disadvantage with regard to survival. One will have a greater risk, for example, of developing rickets. However, if the environment were to include vitamin D-enriched milk, as is the case in modern circumstances, the individual becomes well adapted.[35]

Boorse retorts by stating that "being black in Trondheim or white in the Sahara is neither disease nor pathological, though each condition raises the risk of disease, as

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[34] Boorse, "A Rebuttal on Health", 29.

[35] Ibid., 30.

Englehardt observes."[36] Englehardt's concern over intraspecies variability is, however, an important consideration for diagnosing and treating such conditions so that they do not raise the risk for disease. Furthermore, without knowing that goals differ among individuals, groups, and the environments in which they live, one would be unable to determine whether a condition is just that, or a disease. And, in either case, treatment may be necessary, whether it is in the form of altering one's body, possibly improving function, or altering the environment in which one lives, e.g., providing vitamin D-enriched milk in Trondheim.

Boorse believes, however, that Englehardt's analysis of disease misses a crucial point, "the gap between medical treatment and the medical concept of disease."[37] Englehardt defines the concept of disease based on what doctors diagnose and treat, a concept fixed by medical practice. Boorse contends that Englehardt slides "more or less indifferently between "disease" and terms like "medical problem" and "clinical problem" as if they were synonymous."[38] Those conditions deemed as medical or clinical problems are not necessarily diseases. This of course is not a new fact. There are several types of conditions people have, which are not diseases, but are "treated" by clinicians. An unwanted pregnancy, for example, involving either abortive pharmaceuticals or surgery, and a clinician either prescribing or performing the abortion, may be regarded as a medical problem for the individual wanting an abortion, but never a disease. Arthur Caplan argues that health care professionals see their jobs as being more than just the

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[36] Ibid., 30.

[37] Ibid., 26.

[38] Ibid., 26.

alleviation of pain or eradication of disease. Health care professionals may see their role as improving the health of their patients.[39] Improving the health of patients may even include changing a patient's physical appearance through plastic surgery so as to improve his or her own self-image.[40] This of course raises serious questions as to whether physicians should see their role as improving patients' health besides alleviating or curing disease.

Another normative concept, which is related to disease, is the notion of illness. In this sub-section, I will examine this notion, which will be an integral component in chapter 4, where I will be looking at whether mental illness, as it is so commonly termed, should be, in fact, be called "mental disease".

Illness as a Concept

The way we talk about disease (or avoid talking about disease) may involve using terms signifying and interpreting the various ways disease can affect the individual. For example, instead of saying the man with poor vision is diseased, or has a disease, one may say that the man has defective eyes. The use of these terms, commonly viewed as subclasses of disease, or distinct concepts related to disease, including malady, disorder, syndrome, infection, defect, lesion, and illness, intending to clarify the notion of disease and its variegated interactions with the person and his or her body, may, in fact,

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[39] Caplan, 55.

[40] However, one may argue that if one's self-image needs to be improved through radical surgical means, perhaps there is some psychological or mental problem that requires attention. There may be a fine line between improving one's health (e.g., inoculations) and masking a problem, which may or may not be a disease (e.g., drastically altering a depressed patient's appearance through plastic surgery to improve her mental well being).

contribute to the *misunderstanding* of disease due to the variability and vagueness of their definitions and uses. These subclasses and related concepts are arguably normative, since their clinical usage, for example, is embedded in the values and interests of healthcare professionals in developing taxonomy of disease.

Subclasses and related concepts of disease make for an interesting topic, however I will be addressing only one particular concept - illness. This concept exemplifies the subjective experiences of the individual, i.e., the mental and/or physical experiences of symptoms, which are neither necessary nor sufficient conditions for disease. Illness is different from disease with respect to what the patient *feels*, which may be linked to what the patient may or may not *know* about his or her disease status.[41] If a person were to experience symptoms such as pain, which often indicate the presence of a disease, we would say that the patient is ill, regardless of whether the patient does or does not have a disease. If a person has a disease but does not experience associated or unassociated symptoms of that particular disease, we would say this person is not ill. In other words, one could be ill and not have a disease, be ill *and* have a disease, or have a disease and not be ill.[42]

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[41] Here I am referring to when a patient may feel ill due to symptoms associated with the known disease or when a patient may feel ill because s/he knows that s/he has a disease, but the illness is not attributed to symptoms associated with the disease. In other words, a person can be ill and diseased at the same time but the illness and disease are psychologically and not physiologically related.

[42] The following illustrates the various interactions among disease, illness, and those agents who either have and/or experience the disease or illness and those who diagnose and treat the agent.

1. A person has a disease and does not know that s/he has a disease.
2. A person has a disease and suspects, but does not know that s/he has a disease. Suspicion is based on the person feeling ill. S/he may or may not have an interest in confirming suspicion, i.e., clinical diagnosis.
3. A person has a disease, feels ill, and knows that s/he has a disease. The knowledge of having a disease is based on clinical testing/diagnosis.
4. A person has a disease, does not feel ill, but knows that s/he has a disease. The knowledge of having a disease is based on clinical testing/diagnosis.

In order to account for the normative features of the concept of disease, i.e., subjective experiences of the medical patient, Boorse introduced the concept of illness. Illnesses are those diseases that have certain normative features reflected in the institutions of medical practice.

Boorse claimed that a disease is an *illness* only if it is serious enough to be incapacitating, and therefore is,

1) Undesirable for its bearer,
2) A title to special treatment; and
3) A valid excuse for normally criticizable behavior[43]

Boorse illustrates a revision in his disease- illness distinction. He believed that the wrong concept, illness, was chosen to illustrate the distinction between value-free theoretical vs. value-laden practical concepts of health. Boorse boldly changes his mind about whether illness is a value-laden concept; illness and disease he now maintains, are

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5. A person does not have a disease, but suspects s/he has a disease because s/he feels ill. Clinicians have an interest in finding whether this person has a disease.
6. A person does not have a disease, clinicians have confirmed that this person does not have a disease, but person still feels ill. Clinicians/patient have an interest in treating the illness.
7. A person does not have a disease, but believes s/he has a disease because clinical testing/diagnosis indicated a disease. In actuality this is a clinical misdiagnosis.
8. A person has a disease (8b. may feel ill), confirmed by clinical diagnosis, and family, or some other third party, makes a particular judgment or belief surrounding this disease, e.g., its cause, who is responsible, who is to blame. Such judgments/beliefs are made in conjunction with the patient and/or clinician and may or may not be justified.
9. A person does not have a disease but feels ill. Family or other third party makes a particular judgment or belief surrounding the illness and has an interest in determining whether the patient has a disease and/or treating the illness.
10. A person has a disease, confirmed by clinical diagnosis, and family, or some other third party, makes a particular judgment or belief surrounding this disease. Such judgments/beliefs are made without the patient and/or clinician and may or may not be justified.

[43] Boorse, "On the Distinction between Disease and Illness", 61.

both value-free concepts. His first reason for changing his mind was that illness could not apply to plants and animals.[44] However, he does not sufficiently explain why it is problematic to hold onto the value-laden concept of illness. Boorse illustrates a semantic peculiarity in that we do not call sick animals "ill" for the same reason we do not call dead animals "deceased".[45] However, this does not explain why illness cannot apply to plants and animals, or why it *has* to apply to plants and animals. The best evidence that values play no role or at least need play no role in the definitions of health and disease is that the analysis he proposes works as well for assessing the health status of plants and animals as it does for humans.[46]

The second reason Boorse changed his mind rests on the belief that the difference between disease and illness does not seem to be a difference of severity.[47] He uses the example that when a person is ill, he or she is less disabled from normal activities than if he or she were blind or paraplegic, which are diseases. Furthermore, these concepts are both value-free; the only difference being the localization of disease (where and how disease affects the organism). Boorse states,

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[44] Boorse, "A Rebuttal on Health", 11.

[45] Boorse, "A Rebuttal on Health", 12.

[46] Caplan, 57.

[47] In "A Rebuttal on Health" in *What is Disease?*, 12, Boorse explains why he changed his mind in thinking that he chose the wrong concept (illness) to illustrate the distinction between non-normative and normative concepts of health. He gives two reasons, however the second reason is not well explained. He states that the difference between disease and illness does not seem to be a difference of severity, but he does not explain what he means by severity. From his example (as explained in the thesis) it seems as though severity suggests degrees of debilitation. I believe there is a difference between disease and illness in that illness is understood to be what the subject of disease – the person – experiences. The experience(s) is (are) typically disturbing and abnormal, and may indicate that a disease is present (although this is not always the case).

> It is because "sick" (or "ill") refers to systemic rather than local disease, to disease which in some sense incapacitates by permeating the whole organism, as do infectious diseases via blood-borne substances and disruption of central homeostasis. But this term "systemic," though vague, is a physiological or pathological term, not an evaluative one. Consequently, I now consider "disease" and "illness" equally value-free. At worst, "illness" is value –laden if the degree of (systemic) incapacitation required for illness involves evaluative choice; but some have urged this thesis regarding "disease" as well.[48]

Although Boorse changed his mind regarding the nature of illness, I believe his initial consideration for developing a concept to account for the subjective experiences of persons was right. If we look at the biological capacities of plants, animals, and humans, we can assume that a plant (as with possibly some animals) is unable to subjectively experience related or unrelated symptoms of disease. We do not have to apply the concept of illness to all organisms, especially those who are unable to have subjective experiences of disease and related phenomena. Also, it does not make sense to call a systemic disease an illness, when it is, in fact, a disease. We need to account for the fact that a patient can experience symptoms either related or unrelated to disease, without

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[48] Boorse, "A Rebuttal on Health", 12.

actually having a disease. This phenomenon, I maintain, is what we call "illness." The difficulty with this view, however, is when a patient displays symptoms, because he or she has a disease, but the disease goes undetected. We may say that this patient is ill, but in reality, he or she is diseased.[49]

In looking at conceptions of disease and illness from non-normative and normative perspectives, I believe both perspectives are useful for understanding disease. Instead of taking a middle position between the two perspectives (such as Boorse's weak normativism or Englehardt's descriptive-evaluative view), I believe both non-normative and normative perspectives can be used in the coherence framework. Boorse's non-normative perspective is useful for describing which human biological functions are abnormal in a particular reference class. Although it can be said that Boorse's non-normative conception of disease is really normative since determining statistical normality involves interests of the statistician and/or biologist, e.g., drawing the line between what is normal vs. what is abnormal, this perspective suggests there are objective criteria for determining which phenomena are diseases, as well as identifying which member of a species has a disease and why. On the other hand, Boorse's non-normative conception of disease is problematic in that it does not account for *persons*; it does not account for the fact that persons are more than biological organisms. Persons have interests and these interests may affect the way in which we understand, diagnose, classify, and treat disease. Many diseases would not have be identified without the subjective experiences of the person who realized that he or she did not feel good and

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[49] To eliminate the confusion among terms including disease, illness, sickness, malady, and so forth, I use the term disease consistently throughout this project. In using the term disease, I include the subjective experiences of the patient in relation to the disease he or she has.

chose to find out why he or she felt this way and how to alleviate the physical and/or psychological disturbance.

Englehardt's conception of disease is useful in that it takes into account the fact that persons have values and, in determining whether a person has a disease or not, the subjective experiences of the patient are critical for diagnosing and treating disease. But Englehardt's normative conception of disease is problematic in that it emphasizes that disease is a mode of analyzing and explaining certain phenomena *for the purposes of diagnosis, prognosis, and therapy.*[50] A conception of disease is useful for diagnosing and treating patients, but not all patients who are diagnosed and treated have diseases and not all diseases need to be treated. A conception of disease should involve both normative and non-normative aspects. Depending on the circumstances in which disease is to be analyzed and explained, e.g., clinical practice, a normative conception, non-normative conception, or both may be useful.

A Coherentist Conception of Disease

Now that I have briefly described the two different approaches to the concept of disease (and the concept of illness), I briefly show how these concepts can be incorporated into a useful framework to provide a better understanding of disease. Instead of taking important and useful elements from normative and non-normative theories of disease, and constructing a middle position between the two, I want to show

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[50] Ibid., 43.

that disease is not a static concept but a dynamic one that adjusts respectively to the demands of metaphysical, epistemological, and ethical considerations. My conception of disease has both normative and non-normative aspects, which may be viewed independently, or together depending on the question(s) being asked and the problem(s) or situation(s) at hand.

A. Working with the Framework

As previously mentioned, some philosophers believe the concept of disease can be properly understood from a normative perspective. They suggest that what we do not know about disease and its relationship to people becomes clearer based on subjective experiences of patients and the interests of those detecting, classifying, diagnosing, and treating disease. There are different but overlapping interests, e.g., the desire among clinicians and patients to treat disease. Although I support these philosophers' views in that the concept of disease is value-laden with respect to the interests of the patient, healthcare professionals, and others, it is important that we understand disease and the interests surrounding this concept from non-normative perspectives as well. A coherence framework can help us understand why we have certain interests and the role(s) those interests play in clinical and social practices. In this section, I describe how a physical disease can be understood through metaphysical, epistemological, and ethical considerations. The purpose at this stage is not to put the framework in motion, where each element of the framework is dynamically interrelated, but to show, at its infancy, how a framework could be constructed to achieve a better understanding of disease. In the next chapter I describe the framework in greater detail and illustrate how we go back and forth between the dynamically interrelated elements to achieve a coherent fit, thus giving us a better understanding of disease.

When a person has a disease such as lung cancer, metaphysical, epistemological, and ethical questions arise. From a metaphysical perspective, ontological and physiological theories of disease may provide answers to such questions as: "Is disease an entity?" "Is disease something that is below species-typical functioning?" From a non-normative, physiological perspective we would say that the patient with lung cancer has a disease, since he is falling below normal species-typical functioning due to abnormal cell growth in the lungs.

Another metaphysical aspect to consider is the subject of disease, or that which disease is predicated on. One may assume that from the above non-normative conception of disease that the subject of disease in this case must be the malfunctioning lung invaded by cancer - a disease entity. What clinicians see is a discolored lung with abnormal cell growth, and in asking the metaphysical question "What is *it*?, it becomes evident, based on what clinicians know about abnormal cell growth and the human body, that *it* is cancer.

Besides looking at metaphysical considerations (in this case looking at lung cancer from a non-normative perspective), epistemological considerations also need to be examined. As mentioned above, clinicians determine *what it is*, by using what they know about disease and its effects on the human body. However, clinicians also know what it is like to be the patient with lung cancer based on clinical observations, patient reports, and possibly their own experiences with cancer. And, in addressing what it is like to be the patient, this epistemological consideration gives us reason to modify our previous metaphysical consideration that the subject of disease is the malfunctioning body, or specifically, a disease entity invading the body. Although it is true that cancer causes the body to malfunction, this is only one aspect of the subject of disease and one aspect of the conception of disease. In the next chapter, I show that the subject of disease is neither the body nor the mind, but the embodied mind – the person and not merely their bodies or parts of their bodies. Using this holistic approach I show that patients, such as the patient with lung cancer, are the subjects of disease. Cancer affects the psychophysical self; patients with lung cancer experience physical and psychological symptoms and hold certain values about disease and what it is like to be diseased.

By looking at clinical practice and the subject of disease – the patient as person, significant epistemological questions are addressed such as, "How do we know a patient has a disease?" "How do we know what it is like to be the patient with a disease?" "How do we know what it is like to experience an illness?" The role of disease as a value-laden or normative conception becomes evident when the person with lung cancer may feel ill (experience pain and discomfort) and seek medical attention possibly even before knowing a disease is present. The *person*, and not the malfunctioning lung, has an interest in alleviating his or her pain and discomfort. Clinicians also have an interest – they want to find out what is wrong and treat the problem. To gain a better understanding of the disease, the clinician may need to revisit the epistemological question, "How do we know the patient has a disease?" Clinicians, upon realizing this individual's body does not function properly based on diagnostic tests and the patient's report of symptoms, can then diagnose and begin to treat the person with lung cancer. This way, the clinician can prescribe medication, psychotherapy, or any other means of treatment to alleviate those disturbing symptoms the person experiences. What the clinician prescribes may not be intended to cure the disease, but help the patient in eliminating or reducing the negative symptoms directly or indirectly related to the disease. For example, the patient diagnosed with lung cancer may experience physical pain, but also may be depressed about his or her diagnosis and need clinical psychological or psychiatric help, especially when the patient begins to blame himself or herself for getting cancer.

Certain ethical considerations address those concerns regarding blame and responsibility. The patient may try to understand why he or she has cancer and look to find causes for the disease; e.g., "Did smoking cause my lung cancer?" In looking for causes, the person may even blame the environment, himself/herself, or others for causing the cancer, e.g., "If I did not smoke, I would not have this disease!" "Working in that polluted factory all these years damaged my lungs!" By blaming oneself or others, further interests may develop, e.g., taking legal action to improve unhealthy work environments, stopping behaviors thought to cause the disease such as smoking, working to improve the health of others in similar situations, and preventing future health problems. In seeking causes for disease, determining who or what is responsible, and determining who or what should be blamed, misconceptions about what disease is and how it affects the individual often develop. These misconceptions, which can even develop within medical communities, can and have contributed to the stigmatization of diseases and those who have them.

The meanings and values attached to the disease and the person experiencing symptoms associated with the disease can be as powerful, if not more powerful, than the effects of the disease itself. In briefly describing how particular diseases such as lung canc

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cancer can be understood using a coherence framework, in subsequent chapters I show how this now static framework can be set in motion, whereby each element of the framework becomes interrelated and dynamic.

In the next chapter, *The Diseased Embodied Mind*, I describe the method of wide reflective equilibrium (WRE) and a coherence framework similar to WRE to gain a better understanding of mental disease. I examine more closely why it is important to understand the subject of mental disease as a person – an embodied mind. I also examine the importance of using biomedical and psychosocial models in clinical practice to diagnose and treat the patient as person with mental disease. Finally, using the example of autism, I show how metaphysical, epistemological, and ethical dimensions become mutually supportive to achieve the best fit to develop a better understanding of mental disease.

CHAPTER 4

THE DISEASED EMBODIED MIND: CONSTRUCTING A CONCEPTION OF MENTAL DISEASE IN RELATION TO THE PERSON

Introduction

At the end of one of her lectures, Dr. Temple Grandin, an autistic Ph.D. in animal science, states, "If I could snap my fingers and be nonautistic, I would not- because then I would not be me. Autism is part of what I am."[1] Due to her childhood inability to speak, apparent deafness, lack of interest in people, intense tantrums, and display of other abnormal behaviors, Grandin was first labeled "brain damaged". Eventually clinicians started to investigate the nature of these symptoms, and characterized them under the label, "autism", necessitating changes within disease classification systems and medical models of clinical practice.[2] Grandin is one of many people labeled and identified with a mental disease who have learned, in their own ways, to interact and connect with the world, even when the world was not always so willing to interact and connect with them. Without making an effort to connect with those who have autism, or with anyone with a debilitating mental disease, we cannot begin to understand mental disease.

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[1] Sacks, Oliver, forward page 16, in *Thinking in Pictures*, by Temple Grandin. Temple Grandin, an assistant professor of animal sciences at Colorado State University, is well known for her designs of livestock-handling facilities, which are products of a different way of thinking attributed to autism.

[2] Temple Grandin, Thinking in Pictures, And Other Reports from My Life with Autism (New York: Vintage Books, 1996.),43.

In working through this problem, trying to understand mental disease and why its various dimensions raise difficulties for our systems of classification and our medical models of diagnosis and treatment, a framework is required. This framework will connect metaphysical, epistemological, and ethical considerations in ways that are mutually supportive and illuminating. This, in turn, will benefit those who are diseased and those persons who study, classify, diagnose, and treat disease. Without a better understanding of mental disease, patients diagnosed with a mental disease may be mistreated clinically and/or socially, and caregivers and families may be wrongfully blamed for causing the disease and/or for not effectively helping and developing meaningful relationships with the patient as person.

The framework I propose is similar to the method of wide reflective equilibrium (WRE) in ethics and social and political philosophy. Before describing this framework, I will briefly describe WRE, as introduced by John Rawls and developed by Norman Daniels to address questions of justice, and then extended by Kai Nielsen and others to address ethical questions.

A. The Method of Wide Reflective Equilibrium

The practice of ethics and social and political philosophy involves trying to solve various problems. In identifying a person's framework for moral reasoning, Norman Daniels writes, "we begin by collecting the person's initial moral judgments and filter them to include only those of which he is relatively confident and which have been made

under conditions conducive to avoiding errors of judgment."[3] In other words, the framework starts with our secure considered judgments about particular cases, and then seeks to match these judgments with equally secure, general moral principles.[4] At this stage, which is characterized as narrow reflective equilibrium, our considered judgments about cases cohere with considered judgments about general moral principles. But, as Kai Nielsen writes, "this narrow or partially reflective equilibrium would never give us a critical morality."[5] In order to achieve critical morality, we must also consider our background beliefs and theories about morality and the world, and bring them into our framework, finding coherence among these and our other two components, specific moral judgments and general moral principles.

The specific moral judgment, "killing Jones is wrong", is a judgment about a particular case or situation. General ethical principles include those such as "treat people as ends-in-themselves, not merely as means" or "do no harm." Background beliefs and theories include, for example, scientific beliefs, metaphysical beliefs about persons and whether there is a God, and beliefs about the nature of morality. Nielsen writes, "The overarching aim is to get the best fit possible of all these diverse elements, elements which are themselves the best warranted elements in their respective domains. With such elements, taken together, we seek to forge a coherent package."[6] A person then works

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[3] Norman Daniels, "Wide Reflective Equilibrium and Theory Acceptance in Ethics," *Journal of Philosophy*, 76, no. 5 (May 1979): 256-82.

[4] Kai Nielsen, "Relativism and Wide Reflective Equilibrium," *Monist*, 76, no. 3, 317.

[5] Ibid, 318.

[6] Kai Nielsen, "Reflective Equilibrium and Transformation of Philosophy," *Metaphilosophy*, 20, nos. 3 and 4 (July/October 1989), 241.

back and forth between each of the three main elements, making adjustments to his or her particular moral judgments, moral rules and principles, and background theories and beliefs in the light of the others as needed to preserve or extend coherence. These three components are in a reflective equilibrium when they are mutually supportive, fitting together as a unified whole. Nielsen writes, "we weave and unweave the fabric of our beliefs until we get, for a time, though only for a time, the most consistent and coherent package which best squares with everything we reasonably believe we know and to which we, on reflection, are most firmly committed."[7] The unified whole, the fabric of our beliefs, provides a substantive moral framework with which new cases and unconsidered situations are addressed.

The method of WRE presupposes that neither moral principles nor particular judgments nor background beliefs and theories can ultimately be justified independent of the others. Also, no element of WRE is immune to revision. In restoring equilibrium, any of the three components may be modified. None is more basic than the others. The method of WRE is not static; the web of beliefs may have to be rewoven in the light of new knowledge or circumstances. WRE is a form of coherentism; beliefs are justified by the extent to which they cohere with the others.

B. Using a Coherence Framework to Understand Mental Disease

To develop a better understanding of mental disease, I propose we emphasize the way certain considerations must, in light of each other, cohere as a unified whole. Once

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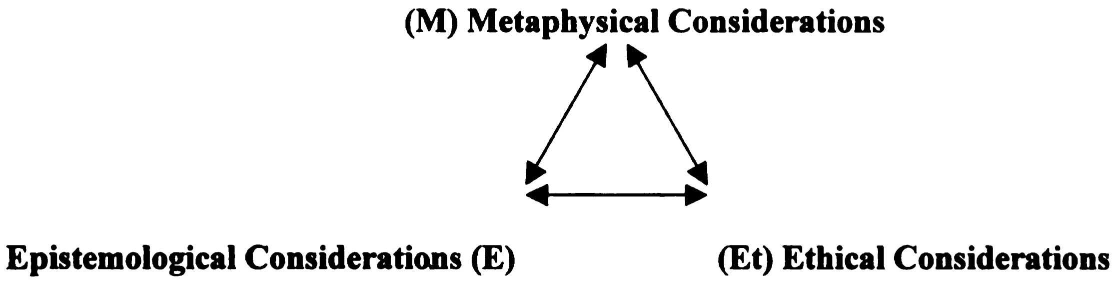
[7] Kai Nielsen, "Relativism and Wide Reflective Equilibrium," 318.

we identify the main elements of the framework, we can then begin to work back and forth between them just as we would using the method of WRE. The important difference is that we develop a better, comprehensive understanding of mental disease through the dialectical interplay among each of the elements. Our current knowledge of medical science, technology, and society is useful for constructing this framework. Because new understandings and discoveries may replace old ones, it is important to account for these changes and modify the framework, if necessary, by working back and forth between elements once again until each coheres with the others, restoring a "fit" based on our new knowledge. The following diagram depicts the coherence framework and the method of moving back and forth between the philosophical elements.

Figure 3: The Coherence Framework



In the following sections, I describe each element of the coherence framework independently, pointing out certain features I believe to be important for understanding mental disease. The elements are the metaphysical, epistemological, and ethical considerations related to disease. Finally, I describe, using the example of autism, the process of working back and forth between elements until they become mutually supportive, thus achieving a coherent fit and illustrating a better conception of mental disease.

Metaphysical Considerations

The metaphysical considerations involve, but are not limited to, aspects of the philosophy of mind. They center on the nature and existence of *disease* and its relation to the human *person*. To assume mental disease is a property of only the mind and/or the brain (body) is to begin in the wrong place for understanding mental disease. To understand mental disease, we need to start with the question, " Of what is mental disease predicated?" The subject of mental disease, I argue, is an embodied mind - a holistic organism with both physical and mental properties, which are distinguishable but unable to be metaphysically separated. Nor can one be reduced to or replaced by the other.

A. The Subject of Mental Disease: The Embodied Person

The Cartesian and materialist traditions distort the conception of person when independent conceptions of mind or body (or brain) are themselves viewed as the subjects of thought, emotion, behavior, and will. P.M.S Hacker writes, "The very conception of the nature of a human being that had dominated the [Cartesian and empiricist] philosophical tradition was distorted. It had been distorted not through folly or blindness, but by the pressure of philosophical questions concerning the essence of the self, the nature of mind, the possibility of self-knowledge, the relation of mind and body, and the possibility of knowledge of other minds."[8] Hacker, describing Ludwig Wittgenstein's conception of person, explains that unlike the Cartesian conception of mind as a purely spiritual substance with psychological properties only, the Wittgensteinian conception of a human being is a psychophysical unity –"a living creature in the stream of life." Furthermore, according to Wittgenstien, embodied persons, not minds, perceive and think, have desires and act, feel joy and sorrow.[9]

P.F. Strawson, holding a similar view, believes there are two kinds of predicates, mental and physical, and two kinds of entities, material bodies and persons. Physical predicates are ascribed to material bodies and both physical and mental predicates are ascribed to embodied persons. On Strawson's view mental predicates are ascribed to an entity only if it can be identified as an individual, which requires that it exist in the physical world. He states that for anything at all to be the subject of mental experience there must exist individuals with the capability of having both mental and physical predicates ascribed to them.[10] These individuals are what he calls "persons".

The Strawsonian-Wittgensteinian account of persons is very useful when looking at conceptions of health and disease. Instead of saying that our bodies walk, or our disturbed minds should go to the clinician, we speak of embodied persons walking, feeling pain, suffering, needing medical care and treatment, and being taken or taking themselves to the doctor. As Hacker puts it, "… we speak of human beings as sufferers, not of their bodies or their minds. And the way we speak meshes with our lives, is

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[8] P.M.S. Hacker, *Wittgenstein,* (New York: Routledge, 1999.), 5.

[9] Ibid., 4.

[10] P.F. Strawson, "Persons", in *Minnesota studies in the philosophy of science,* vol. 2., H. Feigle, M. Scriven, and G. MaxwelL (eds.) (Minneapolis: University of Minnesota Press, 1958.), 349.

interwoven with our behaviour, actions and reactions. We tend the injured limb, but we comfort the person who is injured and pity him."[11]

Although scientists and clinicians may speak loosely of the diseased brain or the abnormal mind, the embodied person, who behaves, thinks, or feels in ways that are unusual or abnormal, is characterized as ill or diseased. Being characterized as mentally diseased has biological and psychosocial implications. From a biological perspective, the focus of mental disease is the brain and/or central nervous system; what gives rise to our cognitive processes, including behaviors, thoughts, emotions is dysfunctional. For example, there are several types of brain dysfunction among persons diagnosed with autism; various nonspecific neurological symptoms or signs are often noted (such as primitive reflexes), along with evidence pointing to abnormalities in the limbic system. Although the causes and pathology of autism are unknown, abnormal behaviors (such as repetitive motor mannerisms, delay in or total lack of spoken language, inability to develop peer relationships) provide evidence to suggest the brain is abnormal or malfunctioning.

The multitude of psychosocial perspectives, on the other hand, with political, moral, religious, and cultural overtones, places a heavy burden on the embodied person with a mental disease, who may be blamed, pitied, ignored, or despised. For example, autistic children are often the subjects of public scrutiny, especially when displaying abnormal behaviors such as tantrums, repetitive motor mannerisms, and aggressive behaviors toward others and themselves. These children are often called "stupid" or

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"weird", even though they may be high-functioning, intelligent persons. Family and friends may also be ridiculed or blamed for causing the disease or for not doing something about it. Before some of our current medical and scientific theories regarding the nature of autism took hold, clinicians actually believed parents, especially mothers, caused childhood autism.[12]

The subject under psychiatric investigation is not just a biological organism or just a psychosocial being, nor is it an additive lamination of the two. In an embodied person, the biological body and the cognitive mind are interactive, unified, and whole; when a subject is mentally diseased, an abnormality or a malfunction affects the person as a whole, and not merely the body or mind. Moreover, there is as a rule, something it's like – from the inside – to be a person with a mental disease. This, as we will see, is one important link between the metaphysical and epistemological and ethical dimensions of mental disease.

B. Conceptions of Mental Disease

The status of mental disease has generated a debate among those who define and understand mental disease as a non-normative conception, a normative conception, or a mixture of both. Non-normativists look at the theoretical heart of medicine, whereby disease is understood through a body of objective, scientific knowledge. Normativists, on the other hand, look beyond the theoretical heart of medicine, and acknowledge the

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[12] Because many autistic children cannot develop relationships and/or initiate and hold a conversation with others, clinicians once thought these behaviors to be imitations of the behaviors presented by the child's insensitive, cold "refrigerator mother", who failed to establish a loving relationship with her child at infancy.

fact that medicine is the clinical practice of diagnosing and treating *persons,* and thus disease cannot be understood without considering values. Those, like Thomas Szasz, hold an extreme view, suggesting that if we cannot identify the non-normative nature of mental illness, then it must be a myth.

In considering the question, "Is there such a thing as mental illness?" psychiatrist R.E. Kendell seeks to "decide whether mental illnesses are legitimately so-called".[13] Both Kendell and Szasz turn to the general concept of disease, acknowledging certain difficulties of definition, but suggesting criteria, which they take to be self-evidently essential to its meaning. Szasz's criterion of disease is a "deviation from the clearly defined norms of the structural and functional integrity of the human body."[14] He points out that for mental diseases, however, the relevant norms of bodily structure and functioning are not available yet. On the contrary, he argues, the norms of mental illness are ethical, legal and social.

Kendell, on the other hand, views mental disease as a non-normative conception, and claims that mental diseases are really no different from physical disorders. He defines both mental and physical diseases as a "non-normative disadvantage, which must embrace both increased mortality and reduced fertility."[15] Kendell draws on epidemiological and statistical data to show that many mental illnesses are biologically disadvantageous, and associated with reduced life and/or reproductive expectations.

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[13] K.W.M Fulford, "Analytic philosophy, brain science, and the concept of disorder" in *Psychiatric Ethics*, 3rd edition, Sidney Bloch, Paul Chodoff, Stephen A. Green (eds.) (New York: Oxford University Press, 1999.), 168.

[14] Ibid.,168.

[15] Ibid.,169.

Boorse also views disease as a non-normative conception, or "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."[16] However, Boorse treats *mental* disease as a mixed normative-descriptive concept. In viewing mental disease in this manner, Boorse looks at mental disease with respect to his normative description of illness. In describing illness, Boorse points out three conditions; a disease is an illness only if it is serious enough to be incapacitating and is therefore (1) undesirable for its bearer, (2) a title to special treatment, and (3) a valid excuse for normally criticizable behavior.[17] He concludes that the concept of mental disease does not always satisfy these three conditions, and, because it is neither entirely normative nor descriptive, it must be a combination of the two depending on the circumstances. Boorse claims, "we shall assume both that there are natural mental functions and also that recognized types of psychopathology are unnatural interferences with these functions."[18] Looking at Boorse's conception of disease in relation to the person, we can conclude the conception of disease, whether physical or mental, cannot be entirely non-normative, since it is not separate from the subjective experiences of the embodied person. We cannot ignore the fact that disease affects the

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[16] Christopher Boorse, "A Rebuttal on Health", in *Biomedical Ethics Reviews: What is Disease?*, James M.Humber and Robert F. Almeder (eds.) (New Jersey: Humana Press, 1999.), 7-8.

[17] Boorse states that a disease is an illness if it is "serious enough to be incapacitating". What Boorse is trying to convey here is that people have diseases without knowing they have the disease, i.e., there is no experience of symptoms which are physically, psychologically, or socially disturbing.

[18] Boorse, "On the Distinction Between Disease and Illness," *Philosophy and Public Affairs* 5, no. 1, (Autumn 1975), 62.

person holding certain values and beliefs about the phenomenon of disease, including its causes and patterns of symptoms, and how it ought to be classified, diagnosed, and treated.

Epistemological Considerations

In the previous section, I examined a central metaphysical dimension of mental disease; it is predicated of embodied human persons. I explained that there are normative and non-normative aspects of mental disease and that both are necessary for developing a better, general understanding of mental disease. Thus, it is important to consider both biomedical and psychosocial models of mental disease with respect to the patient *in re* clinical practice.[19] In this section I consider the epistemological questions, "What is it like to be the patient?" and "How much do we really know about the disease?" In answering these questions I focus on how mental disease is categorized, classified, and understood in clinical practice in relation to the embodied person.

A. Psychiatric Classification

Loretta Kopelman writes, "the founders of modern psychiatry, including Benjamin Rush and Sigmund Freud, changed how society viewed and treated people who

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[19] Normative and non-normative conceptions of mental disease are considered when viewing biomedical and psychosocial models. The conception of mental disease, the subject of disease, and clinical (psychiatric) practice, i.e., diagnosing and treating patients with mental diseases, are the elements constructing medical models; the biomedical model focuses on an organic diagnosis and treatment (e.g., affecting a patient's neurochemistry to treat depression) and the psychosocial model focuses on psychological and social ways to understand and treat the patient (e.g., psychotherapy is used to understand what social problems may contribute to the patient's depression). I argue that both biomedical and psychosocial models are significant for treating patients with mental diseases - a biopsychosocial model.

were considered "lunatics". As a result of early work in psychiatry, the behavior of the lunatic was reclassified from moral categories such as sinfulness to medical categories such as sickness."[20] There is a great need for classifying mental diseases for clinical, statistical, and scientific purposes, but there has been little agreement on which diseases should be classified and how they ought to be classified. Over the years, classification systems have drastically developed or changed due to several factors. First, scientific and clinical data have been updated because of developments in technology and in diagnostic and treatment practices. Second, psychiatric entities and/or their definitions and descriptions have been instated or eliminated from classification manuals such as the American Psychiatric Association's *Diagnostic and Statistical Manuals*. Finally, social, cultural, and ethical values are now taken into account in current systems. The importance of values in psychiatric classification can be shown directly by inspection of the language used in our current classifications of mental disorders.

However, even with all the significant changes and developments in psychiatric classification, problems still exist. The DSM, although a world standard in the classification of mental disorders, does not contain clear criteria, and even the work groups, contributing their expert and diverse knowledge of illness, reject the idea that each category is a completely discrete entity with absolute boundaries.[21] For example, Autistic Disorder (sometimes referred as childhood autism, Kanner's syndrome, and early infantile autism), is listed under the category, Pervasive Developmental Disorders, along

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[20] Loretta Kopelman, "Moral Problems in Psychiatry." *Medical Ethics*, Robert M. Veatch (ed.) (Boston: Jones and Bartlett Publishers, 1989.), 286.

[21] Such as Grant Gillett, *The Mind and Its Discontents: An essay in discursive psychiatry*, (Oxford: Oxford University Press, 1999.), 50.

with Asperger's syndrome, Childhood Disintegrative Disorder, and Rett's disorder in the current DSM. While some clinicians view these mental diseases to be separate entities, they may, in fact, lie on the same continuum with no definite distinction between them.[22] Grandin states, "Diagnosing autism is complicated by the fact that the behavioral criteria are constantly being changed." For example, Grandin points out that 91% of young children displaying autistic symptoms would be labeled autistic using the diagnostic criteria in the DSM (3rd edition). However, only 59% of children would be labeled autistic in the newest edition (4th edition), due to the narrowing of diagnostic criteria.[23] The authors of the DSM (4th edition) write, "Although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept 'mental disorder'. The concept of mental disease, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations."[24] This relates to the previous section on the metaphysical conception of mental disease; because the conception of mental disease involves both non-normative and normative aspects, the introduction of values especially makes it difficult to define mental disease in a way to cover all situations. Situations are different partly because the values of the embodied person, the subject of mental disease, vary.

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[22] Grandin, 46

[23] Grandin, 45

[24] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision (DSM-IV-TR) (Washington, DC: American Psychiatric Association, 2000.), Xxx.

Those in strong opposition to psychiatric classification systems argue that mental disease cannot be classified like other diseases, since there is little or no physiological evidence supporting the claim that mental disease is a physical malfunction of the brain. For example, Szasz claims most cases of mental disease should be regarded as expressions and reflections of the individual's struggle with the problems of living. According to Szasz, they represent social, ethical, and legal problems, rather than "diseases" in the medical sense.[25]

The DSM and other classification systems of mental disease may not have consistent operational definitions, or may not be able to classify only those diseases that have been shown to have a kind of physical malfunctioning in the brain or central nervous system. However, the empirical and descriptive system of the DSM can be effective when used with expert clinical and scientific knowledge and judgment. Nevertheless, the epistemological problem of developing workable, well grounded, widely shared criteria for identifying mental disease remains.

B. Psychiatric Practice: Diagnosis and Treatment

Many clinicians today, although recognizing both biomedical and psychosocial models of mental disease, often focus solely on the biomedical aspects, investigating apparent physical anomalies in the brain and using pharmacological and surgical methods to treat such malfunctions or abnormalities. Clinicians favor these methods due to the limited success of psychotherapeutic treatments. Another reason is that science has

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[25] Stanislav Grof, *Beyond the Brain: Birth, Death, and Transcendence in Psychotherapy*, (New York: State University of New York Press, 1985.), 319.

advanced significantly; clinical neuroscientists have developed useful pharmacological treatments through investigations in brain chemistry and pathology. Also, other fields focusing on the biomedical aspects of mental disease, such as genetics and molecular biology, have aided in advancements in knowledge about the brain and how it malfunctions. The more we come to know about the functions of the brain, the more we understand how and why it malfunctions.

T.M. Luhrman writes that the new paradigm of biomedical psychiatry has been an enormous advance in the battle against more of a "mentalistic" psychiatry. Luhrman states, "The ability to understand more of the brain's processes has spawned tremendous growth in the exploration of new psychopharmacological treatments...that have transformed the lives of many."[26] However, this biomedical approach, Luhrman fears, will become the only approach to mental illness. She states that there is a moral danger that lies in the way we see patients and the way they see themselves:

> The popularized, vulgarized medical model invites us to see the mentally ill as not quite human, particularly if their problem is chronic and unremitting. It invites us into a moral instinct in which our very efforts to remove the stigma lead us to say that these ill people are not as human, not quite alive, as we are. This is because psychiatric illness is not like liver dysfunction. It disrupts a person's reasoning and feeling. And to say that someone's

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[26] Luhrmann, T.M. *Of Two Minds: The Growing Disorder in American Psychiatry,* (New York: Knopf, 2000.), 284.

> reasoning and feeling are diseased, when the disease never goes away, is to say that she is not fully human.[27]

According to Luhrman, while the biomedical model offers hope for those whom a cure is found, it condemns those whom a cure does not redeem. Luhrman's real fear, as I see it, is that the rise in biomedical treatments will fully replace those current psychotherapies that focus on thought, emotion, and behavior rather than some neurological or biochemical entity. If these neurological or biochemical entities are found to *cause* abnormalities and malfunctioning in the brain and central nervous system, the patient will no longer be responsible for his or her thoughts and actions. But as Luhrman suggests "a patient is better off and has a better prognosis if he learns that despite his illness, he must learn to become responsible for his actions in the world."[28] For example, the autistic child who learns to overcome communication and language barriers, improve sensory and motor skills, and/or control inappropriate behavior through various psychotherapeutic interventions becomes a more responsible person, while finding such achievements to be rewarding.

This argument suggests that mental disease is really a disease of the embodied person, and the clinical response must be to the embodied person. Thus biomedical aspects of disease must be viewed in light of a larger psychosocial picture with the patient as an embodied person in the center. By holding this view, ethical problems

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[27] Ibid., 284-5.

[28] Ibid., 291.

surrounding the therapeutic relationship and patient autonomy, for example, are limited. By viewing patients as persons, clinicians can develop a better understanding of their medical needs including physical, psychological, and social needs. This will be examined further in the following section.

Another important consequence of the tilt toward the biomedical model is a great emphasis on establishing the correct diagnosis of an individual patient and creating an accurate diagnostic or classificatory system. In turn, when accurate and reliable diagnoses and prognoses are available, mental diseases are thought to resemble physical diseases from a medical, scientific, and social perspective. And if persons with mental diseases are viewed no differently from those with physical diseases, social misconceptions and stigmas may be reduced or eliminated.

By integrating biomedical *and* psychosocial models into clinical practice, the patient is treated as an embodied person, rather than biological organism or a disembodied mind. In viewing persons with mental diseases as social, cultural, and moral, "living creatures in the stream of life", we are able to better recognize their clinical and ethical needs, while reflecting upon our own obligations to understand and fulfill those needs.

Ethical Considerations

Ethics, the philosophical study of morality, is concerned not with what is, but what *ought to be*. The ethical considerations at issue here, including judgments made by patients, clinicians, families, and society, govern, among other things, how we ought to characterize and respond to those who are mentally diseased. Because psychiatric medicine involves both biomedical and psychosocial aspects, the aim of this section is to show why both aspects *ought to be* integrated in psychiatric medicine. Disease itself is not the focus in psychiatric medicine, but rather the patient, the embodied person, with the disease.

A. Psychiatric Diagnosis

A diagnosis of mental disease can be helpful in cases where the patient wants to know *what* he or she is experiencing, what can be done about it, and that someone, i.e., the clinician, can identify what it is, and through its identification, can possibly put the patient at ease. Besides identifying the problem, the clinician can also tell the patient that he or she is not alone, and, if available, treatment can reduce, if not eliminate, those symptoms, which are physically, psychologically, and/or socially undesirable. Walter Reich states, "With remarkable ease diagnoses can turn 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."[29] However, a diagnosis of mental disease can also be harmful to the patient, especially if it is a wrong diagnosis or misdiagnosis.

Kopelman suggests there are three important purposes of diagnoses, and indicates how each can be abused. The first purpose of diagnosis is for accuracy or integrity of observation and description. An example of inaccurate diagnosis is a pattern

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[29] Walter Reich,"Psychiatric diagnosis an ethical problem"in *Psychiatric Ethics*, 3rd edition, Sidney Bloch, Paul Chodoff, Stephen A. Green (eds.) (New York: Oxford University Press, 1999.), 205.

of abuse in Soviet psychiatry, where information regarding patients' observable behaviors was falsified and patients were wrongfully institutionalized.[30] Psychiatrists in other countries, including the United States, "have used diagnosis of mental illness to help people 'circumvent the law …get abortions or to help them evade the military draft,"[31]thus, violating the accuracy or integrity of observation and description.

The second purpose of diagnosis, Kopelman explains, is to benefit persons by identifying their needs. Identifying the needs of patients may be useful for healthcare access, reducing the possibility of inappropriate reactions such as anger or blame, preserving confidentiality, respecting patient autonomy, and acquiring descriptive information about the illness. By identifying patients' health care needs, the amount of research, facilities, therapies, and social awareness may also increase.[32] Kopelman explains, "It [diagnosis] might also include consideration of a variety of risks including normative dangers (e.g., the loss of status or freedom), misconceptions (e.g., that mentally ill people are dangerous), irrational attitudes (e.g., the thinking of mental illness as punishment for sin), and the "spread" effect or the tendency to view disabled persons as more handicapped than they are."[33]

The third reason for accurate diagnoses is to benefit society, serving as a research goal, an opportunity for better resource allocation and management, and as safety measure for those who are dangerous to themselves or others.

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[30] Ibid., 205.

[31] Kopelman, 258.

[32] Ibid., 258

[33] Ibid., 267

B. Psychiatric Treatment and the Therapeutic Relationship

Besides family and friends, who are expected to fulfill certain responsibilities (e.g., acting as a support system, preventing harm, seeking appropriate medical attention, etc.), clinicians are also expected to fulfill certain responsibilities, such as providing effective treatment, and are often blamed if obligations are not properly met. Treatment practices involve both biomedical and psychosocial models. The goal of treatment is to benefit the patient by reducing or eliminating undesirable symptoms and evidence of disease. This goal cannot be achieved without scientific research and testing, and especially the patient's report of experiences and symptoms. Ethical problems arise surrounding issues of autonomy, "because there are different opinions about what people ought to be free to do when they are so mentally ill that they may be impaired in their capacity to understand, reason, choose, or act."[34]

To possibly avoid such ethical dilemmas, therapeutic relationships are essential. Physicians ought to discuss with patients, and their families, their medical history and try to understand their thoughts, feelings, and beliefs surrounding the diagnosis, prognosis, and treatment. Generally, patients and their physicians have a cooperative relationship when communication channels are open, the patient is open to treatment, and the physician demonstrates concern about the welfare of the patient. However, not all physician-patient relationships are cooperative, especially when the patient is unable to

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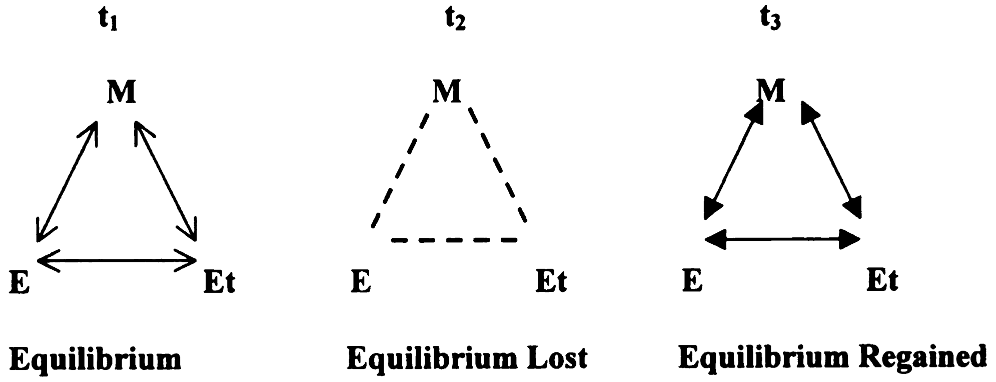
[34] Ibid., 268.

express his or her autonomy due to cognitive impairments characteristic of some mental diseases and/or when the patient is a minor. When situations arise, whereby patient autonomy is limited or cannot be expressed, the therapeutic relationship should cooperate with the beliefs, values, and judgments of the patient's family. By including family in the therapeutic relationship, medical decisions can be better made in the interests of the patient, and not just the interests of either the clinician or the family.

Framing Autism

To show how the coherence framework can be used to understand autism, I put the framework in motion, providing illustrations to show how the elements of the framework can achieve equilibrium as new, unconsidered, or problematic situations and/or information arise. Through this illustration of autism, I show step by step that the framework is not static; rather equilibrium is achieved, lost, and regained (as depicted in the figure below).

Figure 4: The Dynamic Framework: Equilibrium Achieved, Lost, and Regained



Equilibrium is achieved when (M) metaphysical, (E) epistemological, and (Et) ethical elements mutually support and are supported by each other within the coherence framework (as indicated by the arrows). However, when new, unconsidered, or problematic situations and information arise, this may cause disequilibrium or "equilibrium lost", where the elements of the framework are unable to mutually support each other (as indicated by the dotted line). By working back and forth once again between the elements it is possible to regain equilibrium (as indicated by a new set of arrows, illustrating how new information is incorporated into the framework).

Equilibrium

Prior to the 1940's children with what we now call autism were thought to be mentally retarded or "feebleminded". From a (M), a metaphysical perspective, the subject of disease was the severely mentally impaired individual who could not effectively communicate with others or complete simple cognitive tasks. This metaphysical characterization of the subject of disease supported and was supported by (E) epistemological considerations. From (E) an epistemological perspective, or what was known about "feeblemindedness" and what it was like to be a feebleminded individual, clinicians claimed to *know* that these children were mentally retarded, since they displayed abnormal behaviors compared to individuals their own age. Clinicians claimed to know what it was like to be feebleminded by comparing the behaviors of the mentally retarded individual to the behaviors of a small infant. The infant, like the mentally retarded individual could see the world but could only partially interact with it since cognition was not fully developed. This claim contributed to the belief that mental retardation is caused by an underdeveloped brain; it is as though the fourteen year old feebleminded adolescent has the brain of a six month year old infant.[35] Because there was no way to change an underdeveloped brain, or no cure for mental retardation, clinicians believed the most appropriate course of treatment would be institutionalization, where patients could be separated from the rest of society, while being observed and cared for (receiving basic needs such as food and shelter). Thus, institutionalization was not only for the patients' own good, but also for the good of society. From (Et), an ethical perspective, it appeared as though the benefits of diagnosing patients with what clinicians knew at the time, and placing them in an institution, outweighed the harms of not being treated at all or being treated with therapies not designed for mental retardation.

Equilibrium Lost

The stability of this particular coherence framework, however, was compromised when two psychiatrists, Leo Kanner and Hans Asperger[36], observed differences among those who were mentally retarded and those who we would now diagnose with autism. In 1943 Kanner, working at Johns Hopkins University, conducted a study on children who could not communicate and who were unable to form relationships with others. He realized through his observations that although these children could not communicate,

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[35] Often, clinicians relied on such analogies since they did not have the knowledge and tools to distinguish genuinely (cognitively) retarded fourteen-year-old adolescents from what we would now call an autistic fourteen-year-old. Clinicians at the time lumped together intellectual and social/emotional disorders without distinguishing the differences between them; thus, autism was understood to be an intellectual disorder in the same way mental retardation was understood.

[36] Shortly after Kanner's study, Asperger applied the term to children who developed obsessions for particular subjects, but who were extremely intelligent.

they were not mentally retarded; in fact, they were able to complete difficult cognitive tasks. Due to the fact that these children did not display typical behaviors characteristic of mental retardation, (E) epistemological considerations (what we now knew) no longer support or be supported by the relevant (M) metaphysical considerations (what these children were like) and (Et) ethical considerations (how they ought to be treated). In other words, what clinicians *knew* of mental retardation was not true of Kanner's patients. Kanner thus described his patients as *autistic*, characterizing them under a new, less stigmatizing label. This new knowledge, that there was something different from mental retardation, contributed to modifications in (M), i.e., the identification of what is autism, or that *something*, which was different from mental retardation. Furthermore, with this new knowledge about autism, (E) epistemological considerations, or what Kanner and others know about autism, no longer cohered with the (M) metaphysical consideration - the subject of disease, or the severely feebleminded individual. Without modifying (M), certain new (Et) ethical considerations are unable to support and be supported by (M). For example, if Kanner were to characterize his patients as mentally retarded instead of autistic, they would be treated as such, thus forced to carry a stigmatizing label and with it, the possibility of being wrongfully clinically and socially treated.

Equilibrium Regained

Being diagnosed with autism rather than mental retardation was ethically significant for understanding those conditions that did not fit the paradigm of mental retardation (autistic children with a high level of intelligence), as well as for developments in diagnostic and treatment practices specifically designed for helping autistic patients. Also, being aware of poor clinical and institutional practices, in general, could have made clinicians such as Kanner more inclined to develop a less stigmatizing disease label to enhance patient welfare. Thus (Et) ethical considerations such as looking out for patient welfare, also supports (E) epistemological considerations, such as recognizing the need to improve clinical practice and classification systems of mental disease based on what clinicians *know* about the disease and the patient experiencing the disease. In order for (E) to mutually support (Et) and vice versa, a new diagnostic label, "autism" was needed.

Now that autism was distinguished from mental retardation, clinicians began to investigate autism and its causes. From (M) a metaphysical perspective, the subject of autism was typically a child, beginning to experience the world and develop social and moral awareness. The individual with autism, having difficulties in communication and human interaction, along with a variety of abnormal sensitivities to the environment, was not always viewed as a whole person. The subject of autism was not viewed as an embodied mind but the malfunctioning brain and its relation to abnormal and uncontrollable behaviors. However, because Kanner and others recognized the need to improve clinical practice, especially in the care and treatment of mentally diseased persons, autism was described as a disease of the whole person, affecting the psychophysical self and not just the brain or CNS. Furthermore, Kanner and others began to address the important new metaphysical question about what it is like (from the inside) to be an autistic person. This development clearly shows how (M) metaphysical elements support and are supported by (Et) ethical elements. Viewing the autistic patient as an embodied mind and trying to understand what it is like (from the inside) to be an autistic person enhanced clinical diagnostic and treatment practices as well as investigations of autism and its causes.

Autism was eventually described as a disease, developing sometime after birth, and caused by psychological factors. Because autism was believed to develop sometime after birth, researchers and clinicians began to investigate parent-child relationships. Because autistic children could not easily, if at all, develop relationships with others, had difficulties with communication, and, for some, hypersensitivity to touch, autism was believed to be caused by unloving, cold, "refrigerator mothers". From (E) an epistemological perspective, this theory, based on clinicians' observations of their patients and how they interacted with others, especially their parents, explained why it was difficult for autistic children to develop relationships and effectively communicate with others. In other words, clinicians, in trying to know what it was like to be the autistic child, assumed that having autism was like being unloved and wanting to retreat into one's own world, away from others. The only explanation for autism then was that a mother's coldness toward her child caused the child to feel this way, and thus behave similarly. This epistemological perspective seemed to fit with certain (Et) ethical considerations. From (Et) an ethical standpoint, clinicians believed it was their duty to inform new parents of this new presumed cause of autism, and to find ways to prevent its "spread". For example, new parents were advised to develop "strong" loving relationships with their infants to avoid harming them. What was believed about the psychological causes of autism through clinical studies and physician interactions with patients and their families affected metaphysical and ethical dimensions surrounding this disease.

Equilibrium Lost

Given what we know now about autism the coherence framework requires some adjustment; the philosophical dimensions are not able to be mutually supportive, if we are to suppose that what we know now about autism seems to meet the conditions of reflective equilibrium better than the previous illustration. Although the theory of the "refrigerator mother" may have seemed the best explanation for autism at the time, it was actually false and had a harmful effect on the parent. Mothers were blamed for having caused this debilitating mental disease, and, in effect, were burdened with guilt and sadness when, as a matter of fact, their behavior had nothing to do with autism's etiology. From (Et) an ethical perspective, blaming the mother was a regrettable move on the part of clinicians, especially since there was no conclusive evidence pointing to the "refrigerator mother" theory. Blaming the actions of the parent caused significant harm to the individual and to the family as a whole. In looking at the coherence framework, we are able to make adjustments while maintaining certain elements such as (M) the metaphysical element in viewing the autistic patient as a whole person, or embodied mind. Adjustments are made between the (E) epistemological and (Et) ethical elements; providing new knowledge about autism sets the coherence framework in motion. Significant modifications are made in the coherence framework by moving back and forth between (E) epistemological and (Et) ethical elements until a new fit is achieved. For example, the imperative to improve knowledge about autism and the subject of autism led to a better clinical and scientific understanding of what is (and what is not) autism, which, in turn, led to a different ethical response to the parents of autistic children. Instead of blaming parents of autistic children, clinicians began to focus on what measures ought to be taken to improve the cognitive and social skills of their patients, and more importantly, on how one might understand what it was like to be the autistic person. By understanding what it is like to be the patient, further progress can be made in determining what is autism and how one ought to diagnose and treat the subject of autism.

Equilibrium Regained

There continues to be a heightened interest in the epistemological question, "what is it like to be the autistic patient?", however clinicians have found no concrete answers. Many people diagnosed with autism have similar symptoms, but every case is different due to individual interpretations, experiences, feelings, and so on. It is important to get clear on what we know about autism and what we *think* we know about each particular patient with autism, including what it is like, from the inside, to be him or her. Several advances have been made to understand what it is like for the autistic person experiencing, for example, sensory sensitivities. In understanding what it is like for the autistic person to be sensitive to high pitched sounds, for example, clinicians and family become more aware of the environment and take measures to help the autistic person cope with and/or overcome their sensitivities.

Although progress has been made in how clinicians, patients, and others understand autism and the symptoms it characterizes, several complications do arise in diagnosing autism, since there is no determinate physiological evidence that can be used for diagnosis, e.g., abnormal brain scans. Diagnosis, then, is based on a person's display of behaviors, which vary among autistic persons. Due to the variations among cases, clinicians diagnose their patients by trying to put in words those behaviors, which are observed by others or experienced by the patient. For example, some evidence indicates that many persons with autism are "mind blind". Those who have this mind blindness appear to think that what is in their mind is identical to what is in everyone else's mind and that how they feel is identical to how everyone else feels. To some extent, the person with autism cannot reciprocate his or her interactions with others and the world; for example, at a young age, an autistic child cannot imitate an adult who is making gestures or faces – he or she cannot "read" the internal state of another. Examples such as this complicate our understanding of autism. Although tests have been done to examine this phenomenon, we cannot easily or fully get inside the minds of the person with autism to understand what he or she experiences.

Not only do the (E) epistemological complications surrounding diagnosis raise some ethical questions, e.g., not knowing what it is like to be the autistic person experiencing mind blindness or, for the autistic person, not knowing what it is like to be nonautistic, but (M) metaphysical ones as well, e.g., determining what *is* mind blindness and whether it is a symptom of autism or something else. For example, we may have to make adjustments within the (M) metaphysical dimension of our framework if we have some doubt the individual with autism is a *person*, based on our definition. We may need to modify our conception of person to account for the phenomenon of "mind blindness"; however, our current conception of person may be more beneficial to an understanding of mental disease than any others, and thus, it may be better to find a way for this phenomenon to cohere with our conception of person.

A coherence framework is useful in developing an adequate conception of mental disease, as well as, resolving metaphysical, epistemological, and ethical questions that arise for those who are diseased and those persons who study, classify, diagnose, and treat disease. In constructing this framework, we must examine and connect certain metaphysical, epistemological, and ethical dimensions of mental disease. From a metaphysical perspective, I showed that a combination of normative and non-normative conceptions of disease proved more useful in understanding mental disease with respect to the embodied person – the subject of disease. From an epistemological perspective, I showed how these metaphysical elements, the conception of mental disease and the subject of mental disease, are understood in clinical practice through medical models of diagnosis and treatment. I concluded this section by showing the best medical model to answer epistemological questions, such as "How much do we really know about the disease?," is one that involves biomedical, psychological, and social aspects. I then showed the aforementioned metaphysical and epistemological considerations affect, and are affected by, those ethical considerations involving patients' physical, psychological, and social needs and ways to fulfill such needs through clinician-patient- and family cooperation.

Finally, by showing, through the example of autism, that without a better understanding of mental disease, patients diagnosed with a mental disease may be mistreated clinically and/or socially, and those, such as caregivers and families, may be wrongfully blamed for causing the disease and/or for not effectively helping and developing meaningful relationships with the patient as person.

In the next chapter, I examine three philosophically controversial illustrations. The first illustration, homosexuality, is an example of what was once classified as a mental disease but eventually eliminated from classification systems, in part, due to strong opposition from the homosexual community. Although political liberalism aided in the removal of homosexuality from mental disease classification systems, there are other considerations which suggest homosexuality is not a disease. I show, using the coherence framework, metaphysical, epistemological, and ethical dimensions of the framework are *not* mutually supportive when viewing homosexuality as a disease.

The second illustration, the disease once known as neurasthenia, is a historical example of a disease with no specific pathology. I use this example to show how our understanding of disease and how it is classified, diagnosed, and treated develops and changes. Even though neurasthenia is no longer diagnosed in the Western world, and has been eliminated from classification systems, I show that it is a disease and not a fabrication or myth.

The third and final illustration, schizophrenia, is a contemporary example of a controversial disease. Although many believe schizophrenia to be a disease, some suggest it is a myth because no etiology has been found and the symptoms experienced by patients have no empirical basis. Through the coherence framework, I show that both neurasthenia and schizophrenia are diseases unlike homosexuality even though all three illustrations share common features.

CHAPTER 5

MYTH OR MADNESS?: ILLUSTRATIONS OF THE APPEARANCE AND REALITY OF MENTAL DISEASE

Background

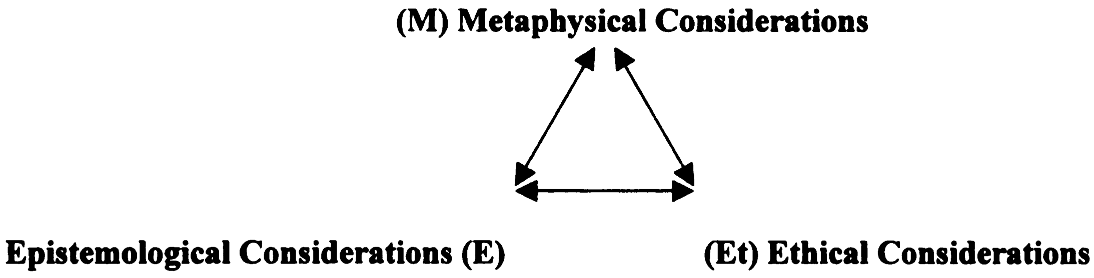
In chapter 4, I showed the nature of mental disease is better understood by finding a "fit" among mutually supportive metaphysical, epistemological, and ethical elements. Using the example of autism, I described how coherence could be achieved when moving back and forth between the elements, making modifications within the framework as new understanding replaced old beliefs about autism. Although we do not know everything there is to know about autism, most would recognize autism as a disease, which physically, psychologically, and socially affects the afflicted person. However, not all cases, where a person is physically, psychologically, and socially impaired or disturbed, are easily recognized as mental diseases. Part of our understanding of mental disease includes recognizing the difference between a mental disease and a myth, i.e. a fabricated or constructed disease label to characterize, in the interests of society social, cultural, moral, and/or political deviations. In this chapter I describe three illustrations of "mental diseases", homosexuality, neurasthenia, and schizophrenia. These illustrations complicate our understanding of mental disease, since they have the appearance of and are called 'mental diseases', but, some would argue they are all myths.

The first illustration, homosexuality, was characterized and classified as a mental disease in the United States until 1973, when it was removed from the *Diagnostic and Statistical Manual,* in part due to strong opposition from the gay community. Although homosexuality is no longer characterized and classified as a mental disease, some believe it *is* a mental disease. Nevertheless, I show, through the coherence of metaphysical, epistemological, and ethical considerations that homosexuality is, in fact, not a mental disease.

The second illustration, neurasthenia, was once America's most diagnosed disease, but "dropped out of existence" because it characterized too wide a range of symptoms; clinicians began to use more precise classifications and characterizations for describing patients' symptoms and the classification of neurasthenia was eventually removed from the DSM prior to the third edition. The question of whether neurasthenia is, or ever was, a mental disease is one that creates some difficulty for understanding mental disease and raises further questions, e.g., "Since mental disease classifications are changeable, are mental diseases merely myths?" However, as I work through the philosophical elements of the coherence framework, I believe it is a question that can be sufficiently answered in the negative. I show that neurasthenia, in one form or another, is a mental disease, even though the classification "neurasthenia" is no longer used in clinical practice in America and was removed, like homosexuality, from the DSM.

The third and final illustration is schizophrenia. Because schizophrenia has no known etiology, no consistent, reliable diagnostic criteria, and a history of abuse (it was used to falsely characterize Soviet dissidents for political purposes), some may believe schizophrenia is not a mental disease but a myth. I believe, due to its broad scope, the classification of schizophrenia, like neurasthenia, will be revised, and possibly removed from classification systems, to account for more precise characterizations and diagnostic criteria. Although this is speculation, the possible connection between neurasthenia and schizophrenia is useful for understanding both as mental diseases. I show, in the final section of this chapter, that schizophrenia is a mental disease, based on the best "fit" of mutually supportive metaphysical, epistemological, and ethical elements of the coherence framework. I conclude by indicating how these illustrations, as philosophically and clinically complex as they are, give us a better understanding of mental disease when working back and forth between the elements of the coherence framework (illustrated below).

Figure 5: The Coherence Framework



Homosexuality

A. Historical Background

Ronald Bayer writes, "Homosexuality, despite periods of greater tolerance, has been considered an abomination in the West for much of the past two thousand years. The very nature of anatomical design seemed to reveal a Divine plan for the morally acceptable use of the sexual organs."[1] Homosexual acts were regarded as unnatural and sinful, violating moral, religious, and social standards. For example, St. Thomas Aquinas believed nonprocreative acts, i.e., homosexual acts, were sinful because pleasure was the sole purpose. For several centuries homosexuals were criminally prosecuted; many homosexual persons were jailed or even sentenced to death. It wasn't until the 19th century that perceptions of homosexuality shifted from an immoral perversion, where the individual was to blame, to a deviancy beyond the control of the individual, and thus labeled a disease, a supposedly morally neutral category.[2]

The belief that homosexuality was a disease alleviated, to some extent, the culpability of the homosexual individual. Instead of directly blaming the individual, medical and scientific communities began to search for the causes of homosexuality and ways to restore the health of the homosexual individual. Even though numerous legal sanctions were changed or abolished, e.g., the death penalty, the disease label of homosexuality negatively affected individuals, e.g., compulsory hospitalization and treatment, suggesting homosexuals were not quite fully persons, especially since they were unable to exert absolute control over their own lives.

Several scientific theories about homosexuality were developed beginning in the last half of the nineteenth century. Scientists attributed homosexuality to an inherited weakness, an inborn predisposition to perversion, environmental factors, deficiencies in human development, abnormal or lack of parent-child relationships, or some combination

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[1] Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis*, (New Jersey: Princeton University Press, 1987.), 15

[2] Ibid., 18.

of these theories. For example in the 1860's Karl Urich wrote that homosexuality was a hereditary anomaly where the genitals developed normally but the brain did not, "and so it was possible for a female soul to be lodged in a male's body." Sigmund Freud hypothesized that boys, developing intense attachments to their mothers, regressed to an earlier stage of development when denied sexual gratification. Since this sexual desire toward the mother was denied, it was transformed, Bayer explains, into a wish to enjoy sex in the way she did, i.e., to receive sexual gratification from the boy's father.[3] Bayer writes,

> In some cases the absence of the mother could determine the homosexual outcome. Deprived of the presence of a woman, the young boy might develop a deep attachment to his father or another older male and as a result seek in his later sexual partners someone reminiscent of the primary object of his love. Alternatively, fear of the anger aroused in his father by the son's oedipal strivings could account for homosexuality.[4]

Following Freud's theory of homosexuality, several scientists have tried to show that homosexuality is a genetic flaw, which may cause an imbalance of hormones, impairment in sexual development, or some other malfunction or abnormality in normal bodily (including brain) processes. Although no theory has been proven, the American

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[3] Ibid., 24.

[4] Ibid., 24-25.

Psychiatric Association listed homosexuality as a sexual disorder prior to the third edition of the DSM (1974).

Due to the demands of homosexuals, the APA reconsidered this classification and removed homosexuality from the DSM. Nevertheless, some still believe homosexuality is a mental disease, since homosexuals are "abnormal" in that they do not conform to social norms or values. However, calling a person diseased because he or she does not conform to society makes no sense, since our understanding of disease is not solely based on values. If this would be the case, the criteria for what is or what is not a disease become arbitrary, possibly harming the individual diagnosed with a disease who may simply hold different values. Yet, a lot of time and money is used to find an explanation for homosexuality. In fact, some believe, homosexuality must be caused by *something* if it's causes cannot be attributed to an imbalance of humors, or evil spirits, or hormones. This reasoning is problematic, however, since many diseases have unknown causes, (as discussed in the following sections). In the next section, I describe the case of Alan Turing who not only experienced the effects of social intolerance, but who also was forcibly treated for his "disease." This case is used to show how homosexuality, even when understood and accepted by the person, was viewed as a disease.

B. The Case of Alan Turing

Alan M. Turing is described by Andrew Hodges as the 'atheist, homosexual, eccentric, marathon-running English mathematician who was in large part responsible not only for the concept of computers, incisive theorems about their power, and a clear vision of the possibility of computer minds, but also for the cracking of German ciphers during

Second World War.'[5] Throughout his life Turing investigated the relationships between machines and nature, especially the nature of the human brain. He believed that machines could be created in the image of the human brain; these machines would be so complex that one would not be able to tell the difference between a machine and a person. Ironically, in his attempt to create a machine in the image of a person, his sexuality kept him from fitting society's conception of a person. Hodges writes, "Like any homosexual man, he was living an imitation game, not in the sense of conscious play-acting, but by being accepted as a person that he was not."[6]

In the late 1930's, Turing went to Princeton, where he developed the idea of what was to become known as The Turing Machine, a machine that could read a series of steps and perform them in proper sequence to complete a particular task. His mathematical and philosophical work revolutionized digital computation and artificial intelligence. Although successful in his innovations, Turing was burdened with a stigmatizing, homophobic society. Interpreting Turing's interpersonal struggles with his sexuality and his relationships with others, Hodges writes, "To keep the self a complete and consistent whole, rather than the split into a façade of conformity, and a secret inner truth, was a miracle. To be able to *develop* the self, to increase its inner connections and to communicate with others – that was next to impossible."[7]

Moving from Cambridge to Princeton, he found American society especially unwelcoming for a homosexual man and "was not ready to make the social adaptation

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[5] Andrew Hodges, *Alan Turing: The Enigma,* (New York: Walker and Company, 2000.), *xii*

[6] Ibid., 129.

[7] Ibid., 78.

that his sexuality, at least outside of Cambridge, demanded."[8] American society viewed homosexuality as a sin, something that was filthy, immoral, and abnormal. During this time, "he could reasonably have felt that there was *no* acceptable adaptation; that this particular mind-body problem had no solution."[9] However, America was not the only society insensitive towards those who did not conform to the ways and beliefs of the general population.

In 1952, after a long period of career successes and praise, Turing was arrested in Britain after police learned of his homosexual relationship with a man from Manchester, Arnold Murray. The crime he committed was that of 'Gross Indecency contrary to Section 11 f the Criminal Law Amendment Act of 1885.'[10] He believed that his actions and beliefs were not wrong, and was, in fact, open about his sexuality. Because violating this law involved possible imprisonment, Turing went on trial on the 31st of March. Instead of going to prison, Turing was expected to seek treatment for his "disease". With the discovery of hormones, clinicians suggested that "the eternal verities of 'masculine' and 'feminine' might, indeed, be embodied in a simple chemical form."[11] Based on this theory, men and women during this time were given injections of hormones to control their sexual urges. Hodges writes, "If the male hormone *increased* sexual 'drive', then the female hormone would *decrease* it – for heterosexual and homosexual men alike."[12]

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[8] Ibid., 127.

[9] Ibid., 127-8.

[10] This act was defined 'purely in terms of parts of the male body, and applied absolutely, irrespective of such factors as age, financial advantage, and whether the activity was in a public or a private place.' Ibid., 458.

[11] Ibid., 468.

[12] Ibid., 468.

Turing's treatment consisted of estrogen injections, which he took for approximately one year after his trial.

In 1954, just two years after his trial, Turing's caretaker found him dead from what authorities believed to be was an intentional cyanide poisoning. Although the coroner stated his death was suicide, Turing's mother believed otherwise, since it was not uncommon for him to work with cyanide in his experiments. She believed that although he faced difficult personal struggles, he would not give his life up so easily and commit suicide. Furthermore, there were no signs pointing to suicide, e.g., he did not appear depressed or dissatisfied with his life.

Twenty years after Turing's death, the classification of homosexuality was removed from the DSM. Some may argue that homosexuality would still be classified as a disease if it were not for gay activists who protested against the APA for classifying homosexuality and diagnosing and treating persons under a false disease label with no therapeutic benefit. Bayer responds by stating, "Political liberalism alone cannot, however, explain the dramatic shift in outlook on the part of psychiatrists. Equally important was the growing confusion about the scope of the profession's concerns and concomitant interest in the development of a narrower, less inclusive definition of mental illness."[13] Bayer writes,

> Psychiatrists responded with great concern to the charge that their diagnostic standpoint had become a major prop

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[13] Ibid., 191.

> for social repression; that the stigmatization brought on by psychiatric classification was especially virulent; that, rather than a source of melioration, psychiatry had become the source of great pain and suffering. Perhaps more than any other group, homosexuals were the victims of what many academic sociologists had claimed was the inevitable consequence of "labeling" deviant behavior.[14]

Once the classification was removed, clinicians in the United States began to focus on those psychological problems, such as depression, that some homosexuals experienced because of society's lack of concern, disrespect, insensitivity, and poor understanding; although the classification was removed, it did not remove the general, stigmatizing views held by society. The stigmatizing views held by society are apparent in cases such as the case of Turing.

To understand Turing's struggles, we need to understand him as a *person*, rather than as a disembodied mind, scrutinized by medical science for the purpose of finding a malfunction or abnormality to classify, diagnose, and treat as a disease. In order to distinguish mental diseases from merely eccentric, different, or unusual behaviors, thoughts, and practices, it is important to understand what mental disease is and also, what it is not. To show why homosexuality is not a mental disease depends on a reflective examination of normative and non-normative conceptions of the relation

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[14] Bayer, 190.

between disease and person, as understood by individuals, clinical professionals, and others.

C. Framing Homosexuality

In this section, I first sketch a conception of homosexuality as a disease, in terms of a possible equilibrium of metaphysical, epistemological, and ethical considerations of the coherence framework. I then show that this equilibrium cannot be maintained when new, unconsidered, or problematic situations and/or information arise, suggesting that homosexuality is not a disease nor can it plausibly be restored.

Equilibrium: Homosexuality is a Disease

In answering the (M) metaphysical questions, "What is homosexuality?"and "Of what is homosexuality predicated?"clinicians at one time believed that homosexuality was a disease and the subject of this disease was the body where a hormonal imbalance occurred, thus affecting the individual's ability to desire and develop relationships with persons of the opposite sex. Theories about hormones and their role in the human body became the focus of clinical and scientific investigation. The (M) metaphysical view that homosexuality was a disease is supported by (E) epistemological considerations involving what clinicians thought they knew about hormones and the human body, homosexuality, and diseases in general. To show that homosexuality was a disease, clinicians compared homosexuality to other known diseases, understanding homosexuality through non-normative and normative conceptions of disease. From a non-normative perspective, clinicians claimed to know that homosexuality was a disease, since sexual preference for the same-sex was abnormal compared to the general population, and that this abnormality, believed to be caused by a hormone imbalance, was responsible for reproductive inactivity. From a Boorsian perspective, reproductive inactivity due to a hormonal imbalance suggests below species typical functioning, thus indicating that individuals who are below species-typical functioning are diseased.

From a normative perspective, homosexuality was viewed as a disease, since clinicians knew, from their clinical observations and interactions with homosexual patients, that many homosexual persons view their sexual orientation to be undesirable. Some homosexual persons, believing they could live a "normal" life, sought treatment from their clinicians and/or hid their abnormal thoughts, beliefs, and behaviors from others. Clinicians saw that these acts, i.e., seeking treatment, hiding one's condition, were similar to those expressed by their patients diagnosed with other diseases, thus, indicating that homosexuality was, in fact, a disease.

(M) Metaphysical considerations, that homosexuality *is* a disease and the subject of disease is the body, connects with certain (Et) ethical considerations. The move from viewing homosexuality as a sin to a diagnosable and possibly treatable disease transferred the cause from the person, committing a sin, to the body, namely the hormonal imbalance within the body. By transferring blame from the person to the body, the homosexual individual is not held responsible for his or her thoughts and actions; the blame is placed on the malfunctioning body over which the individual has no direct control.

The above (M) metaphysical and (Et) ethical considerations also mutually support and are supported by (E) epistemological considerations. For example, understanding homosexuality as a disease depends on what clinicians and their patients know. In answering the epistemological question, "How do we know homosexuality is a disease" clinicians claimed to know that homosexuality was a disease based on what they knew about diseases and the effects of homosexuality, i.e., the symptoms their patients experienced because of their sexual orientation (as previously discussed). Clinicians classified homosexuality as a disease because they recognized certain undesirable physical and psychological problems in their homosexual patients such as depression, believed to be caused by hormonal imbalance.[15] These symptoms indicated that homosexuality was a disease, since patients were not able to physically and socially function properly, e.g., patients' depression and anxiety consumed their lives where they were unable to function in society (such as holding a job). In recognizing that homosexual patients often experienced these undesirable symptoms, clinicians had a moral imperative to provide effective treatment for their disturbed patients. And, because the subject of disease was principally the body with a hormonal imbalance, treatment involved physically altering the body through hormone replacements. Thus, based on what clinicians knew about their patients and the disease, homosexuality, (E) epistemological considerations mutually supported and were supported by (Et) ethical considerations.

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[15] Because society generally believed homosexuality to be an immoral, filthy perversion, this view may have affected clinical classification, diagnostic, and treatment practices. Because homosexual persons did not have the same feelings, thoughts, desires, and behaviors as the majority of society, clinicians believed this abnormal sexual orientation must be a disease with physiological and/or psychological causes. If these causes can be found, then homosexual individuals can be treated so that they may regain normal heterosexual functioning.

Bayer writes,

> The second issue of interest to investigators concerned with homosexuality was the extent to which therapeutic intervention could be expected to restore normal heterosexual functioning…Since it was assumed that all homosexuals suffered from a pathological condition there was no question about the methodological soundness of relying upon patients for a more general understanding of the disorder.[16]

Although clinicians had no significant evidence to suggest that homosexuality was a pathological condition, the symptoms patients expressed, the clinician's desire to understand these symptoms and their causes, and the fact that homosexuality diverged from normal sexual behavior, suggested that homosexuality was not only a disease but a disease that could be treated.

Equilibruim Lost

Much of what we know about homosexuality in general has not changed from when it was viewed as a disease. What has changed is our understanding of what a disease is and the ethical implications for diagnosing and treating patients with diseases. Because our understanding of disease has changed, and with it our beliefs about

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[16] Ibid., 41.

homosexuality, the equilibrium of the previous illustration cannot be retained. In this next illustration, I show that equilibrium is lost, and with it, the view that homosexuality is a disease.

What we know about homosexuality that has not changed from the previous illustration, is that homosexual persons are attracted to members of the same sex and are susceptible to the same physical, psychological, and social harms that a heterosexual person experiences. Currently there are no known biological differences between homosexuals and heterosexuals, or no evidence pointing to malfunctions in the brain or body, e.g., hormonal imbalance, of the homosexual individual.

What has changed about our views about homosexuality is described as follows. From (M) a metaphysical perspective, the subject of disease is not the body, or some part or function of the body (e.g., hormones). The subject of disease, as discussed in chapter 4, is the embodied mind – the person. Instead of focusing on the homosexual person's body and its functions, clinicians began to look at the whole person and try to understand what it was like to be the homosexual *person.* One reason why (M) the subject of disease is modified, is because of new information about hormone treatments. Clinicians eventually realized that hormone treatments did not treat homosexuality, thus suggesting homosexuality was not a disease caused by an imbalance of hormones. Because such theories did not prove useful for clinical practice, clinicians began focus on the person as the subject of disease to develop a better understanding of homosexuality and possible ways to treat their disturbed patients.[17]

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[17] Once clinicians realized that homosexuality was not a disease, they no longer looked for possible ways to treat homosexuality.

By viewing the subject of disease as a person, the epistemological question, "What it is like to be the homosexual person?" becomes significant. In answering this question, clinicians began to gather information about the thoughts, feelings, and behaviors expressed by homosexual persons. And in gathering this information, they began to get a sense of what it was like to be a homosexual person. In some cases, homosexual clinicians were able to explicitly express what it was like to be a homosexual person and why they believed homosexuality was not a disease. Such (E) epistemological considerations had a significant impact on (M) considerations, namely why homosexuality is not a disease and why the homosexual person is not the subject of *disease*. For example, in looking at homosexuality through a Boorsian non-normative conception of disease, it is not the case that homosexuals are diseased in that they fall below species-typical functioning. This conclusion was made, in part, because homosexual persons were able to procreate and some had the desire to procreate and raise a family.

Some would suggest that because homosexual individuals experience disturbing symptoms, this is an indication that a disease is present. Clinicians, at one time, claimed to know that homosexuality was a disease even when their patients did not experience disturbing symptoms. Bayer writes, "In the new nomenclature homosexuality and the other sexual deviations were included among the sociopathic personality disturbances. These disorders were characterized by the absence of subjectively experienced distress or anxiety despite the presence of profound pathology. Thus it was possible to include homosexuality in the nosology despite the apparent lack of discomfort of dis-ease on the part of some homosexuals."[18] However, as further information and clinical knowledge developed, it became clear that homosexuality is not a disease. This can be understood through the coherence framework, as (E) epistemological considerations are unable to support (M) metaphysical and (Et) ethical considerations. What clinicians know about homosexuality and what it is like to be the homosexual person does not cohere with a disease model.

Even though some homosexual persons experience physical and/or psychological symptoms or believe their sexual orientation is undesirable, this does not automatically suggest they are diseased. After clinicians began to look at what it was like to be the homosexual *person*, they realized that undesirable or disturbing symptoms were not caused by homosexuality itself but by the intolerance exhibited by society. Homosexuality is only undesirable when others, who are not tolerant, inflict physical and/or psychological harm, or if the homosexual individual engages in risky sexual acts, which may cause health related problems (e.g., AIDS). Because of this new knowledge about homosexuality, i.e., that it was not directly responsible for patients' undesirable symptoms, this (E) epistemological consideration is unable to support (M), i.e., homosexuality is a disease.

(Et) Ethical considerations are unable to support (M), since viewing homosexuality as a disease has several ethical consequences. For example, a person may seek treatment because he or she *believes* that homosexuality is a disease and is something that can be eliminated or cured. There are no generally successful treatments

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[18] Ibid., 39 In this quote, Bayer is referring to the first edition of the DSM. Homosexuality was classified as a mental disorder in the first and second editions until 1973 (prior to the third edition).

or cures for changing a person's sexuality, although several attempts have been made. Attempting to cure homosexuality has several negative repercussions. Not only are people exposed to harmful treatments which may alter one's physical and psychological self, e.g., hormone treatments, and those, like Turing, who embrace their homosexuality, may be treated unwillingly through social and political pressures. For persons who believe their homosexuality is a disease, clinicians need to understand why such a belief is held and measures need to be taken to help the person accommodate his or her sexuality.

Helping a person cope with his or her sexuality is useful especially when the emotional and physical abuse generated by social attitudes and values greatly affects the psychological well being of many homosexual individuals, e.g., depression, inability to develop relationships, hiding or suppressing their sexuality. Looking at this view from (Et) an ethical perspective, this suppression can be psychologically harmful to the individual because he or she never really feels like himself or herself, even though he or she continues to live life according to the expectations of others. This suppression can also be harmful to others, especially when the homosexual individual tries to engage in a heterosexual relationship, possibly marrying a heterosexual person. Although this individual develops loving relationships with his or her spouse, he or she does not feel entirely fulfilled with these relationships, and believes something is missing from his or her emotional and sexual life. In the end, familial relationships may be damaged if the individual decides to leave and fulfill missing emotional and sexual needs. Having the knowledge that homosexuality is not a disease is significant for understanding what it is like to be the homosexual person and useful for helping individuals accommodate their sexuality while they are confronted with social intolerance.

To conclude, homosexuality should not be viewed as a disease based on the following factors, taken together as a unified whole: 1) homosexuality has no pathology; 2) the known psychological disturbances some homosexual persons experience are not necessarily directly related to homosexuality; 3) many homosexual persons do not believe they are diseased and embrace their lifestyle rather than hide from it; and 4) ethical consequences, i.e., harm to the homosexual person and to others, can occur when homosexuality is viewed as a disease.

Because the metaphysical, epistemological, and ethical dimensions of the coherence framework are not mutually supportive based on what we know about homosexuality and homosexual person, the writers of the DSM were correct in eliminating it from the classification system of mental disorders. However, just because homosexuality is not classified as a disease, we cannot ignore the fact that many homosexual persons are physically and psychologically harmed because of social intolerance. Clinicians and others need to help not only those homosexual persons who are struggling with their sexuality, but also guide those, who reveal their intolerance, toward a more compassionate understanding of difference.

Neurasthenia

In this section I examine neurasthenia, a disease identified in the 19th century and classified as a disease in the DSM until 1974 when it was removed due to its lack of usage among clinicians in the United States. Due to neurasthenia's disappearance from clinical practice and classification systems, some have questioned whether or not neurasthenia was a disease, and if so, what made this disease disappear. However, the disappearance of neurasthenia was not the only factor contributing to the question of whether it was a disease. For one, neurasthenia could not be explained through a biological model of disease, i.e., there was no evidence of physical malfunction or abnormality in the body. Second, there were social and political motives for diagnosing and treating particular groups under the label of neurasthenia, thus suggesting neurasthenia, like homosexuality, was not a disease, but, as Szasz would suggest, a myth.

Those who support the view that neurasthenia was a disease consider its important historical contributions to clinical practice, as well as its close resemblance to diseases classified in current systems, such as chronic fatigue syndrome and clinical depression. Loosmore writes, "neurasthenia, in one form or another, has probably existed, more or less, in all times, where the stress and strain of life have been especially severe."[19] Today people experience the same symptoms once characterized by neurasthenia; the difference is that these symptoms are organized and classified under new disease labels. Also, even though neurasthenia has disappeared from clinical practice in the Western world, it remains a useful diagnosis in China. This fact alone contributes to

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[19] W. Charles Loosmore, *Nerves and the Man: A Popular Psychological and Constructive Study of Nervous Breakdown*, (New York: George H. Doran Company, 1921), 20.

complications in developing a better understanding of neurasthenia through a coherence framework. At the end of this section, I provide illustrations of modifications made within the coherence framework to account for the controversial and complex nature of neurasthenia, as understood historically and today.

A. Historical Background

Throughout the 18th and 19th centuries, diagnoses such as hysteria and hypochondria had undesirable connotations; patients were told they were experiencing imaginary symptoms and that nothing was wrong with them except an overactive imagination.[20] Because there was no scientific evidence confirming the organic nature of hysteria and related diseases, many clinicians believed these diseases were not real; they were convenient labels for social, political, and/or cultural purposes, e.g., clinicians were known to diagnose women with hysteria if they exhibited unsuitable character traits. Although diseases such as hysteria could not be explained in organic terms, some clinicians believed the lack of organic evidence should not dismiss patients' claims of mental and/or physical discomfort. Loosmore explains, "Both doctors and patients required a bridge between these two uncertainties, an organic- *sounding* disease term to explain psychiatric-*looking* illness behavior. But whatever terms are used to describe the malady, the sufferer alone knows what the disease really is, and what a dread shadow it casts over both mind and body."[21]

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[20] F.G.Gosling. *Before Freud: Neurasthenia and the American Medical Community 1870-1910* (Urbana: University of Illinois Press, 1987.), 9-10

[21] Loosmore, 21.

In 1869, George M. Beard, an electrotherapist from New York, coined the term "neurasthenia", meaning "nerve weakness" ("neuro", for nerve, and "asthenia", for weakness), to characterize what was thought to be a distinctive disease entity affecting the nervous system. Neurasthenia became the "organic sounding disease term to explain psychiatric-looking illness behavior". Patients diagnosed with neurasthenia experienced a variety of physical and mental symptoms.[22] Some of the psychosomatic symptoms of hysteria and hypochondria (e.g., loss of feeling, delusions, vague pains, depression) were also included among the symptoms characterized by neurasthenia.

Neurasthenia was a significant disease in that patients were viewed as *persons*, whose experiences of psychological and somatic problems were taken seriously. Gosling writes, "In the writings of nineteenth- and early twentieth-century physicians on neurasthenia one sees quite clearly the concept of wholeness – the assumption that the mind and the body are inseparable."[23]

To convince clinicians neurasthenia was not just another label to characterize imaginary symptoms, Beard attempted to show it was a "real" disease by trying to find its pathology. During this time many clinicians held the belief that "persons possessed a fixed amount of nervous energy, determined mainly by heredity, which acted as a messenger between various parts of the body."[24] Thus, Beard hypothesized neurasthenia was the product of some physical change in the nervous system. He claimed that nervousness or "nerve weakness" was a deficiency of nerve energy, caused primarily by

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[22] Ibid., 20.

[23] Gosling, 8.

[24] Sicherman, 22.

modern civilization. Beard's colleague, A.D. Rockwell, explained "that the primary cause of neurasthenia in this country is civilization itself, with all that the term implies, with its railway, telegraph, telephone, and periodical press intensifying in ten thousand ways cerebral activity and worry."[25] Persons who became absorbed in modern civilization, working harder and faster to keep up with a technologically advancing society, often experienced somatic and psychological symptoms due to poor eating and sleeping habits, a full work day without rest or relaxation, and the need to fulfill unreasonable expectations. Neurasthenia became a respectable characterization for a range of symptoms thought to be caused by "urban living coupled with the competition of the marketplace and the cool, dry climate of America's northeast, "[26] even though its pathology was never found.

However, some would argue that neurasthenia was a myth, created to clinically separate the upper and middle classes from the lower class. It was no secret the neurasthenia label was often misused; persons were diagnosed with neurasthenia instead of hysteria or other stigmatizing diseases that often resulted in inadequate care, demeaning therapies, and institutionalization.

B. The Subject of Neurasthenia

The typical patient diagnosed with neurasthenia suffered from several symptoms in varying degrees, many of which were experienced by those institutionalized for insanity. Sicherman states, "Presumably the persistence and severity of these symptoms

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[25] Gosling, 13.

[26] Ibid., 10.

helped to separate the insane from the neurasthenic, but diagnostic criteria were by no means clear."[27] For a time, those who came from the upper and middle classes, suffering from symptoms under the labels of hysteria, hypochondria, and insanity, were instead diagnosed under the label of neurasthenia to ensure a course of treatment outside of the asylum. Those who came from the lower classes, experiencing the same symptoms, were often placed in asylums, in part because they could not afford care at home. The stigma of institutionalization could not be erased, even for those who recovered and were fortunate enough to be released. Sicherman explains, "For even after recovery, formerly hospitalized patients often continued to be reminded that they had been "crazy a number of years ago."[28] Although Beard and his colleagues viewed neurasthenia to be principally a disease of the business and professional classes, many clinicians did not discriminate among the classes. In the early part of the 20th century, working class, single, young adults were the majority of patients diagnosed with neurasthenia. One theory surrounding the correlation among class, marital status, and age claimed that individuals reaching maturity and facing life changes, such as new careers and marriage, had difficulty establishing an adult identity.

Treating the Patient

Sicherman explains that the neurasthenia label was beneficial to both physicians and patients. For patients, neurasthenia was a more respectable disease than associated diseases such as hysteria, hypochondria, and insanity. Neurasthenia brought legitimacy to

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[27] Sicherman, 26.

[28] Ibid., 27.

distressing psychological complaints. Sicherman writes, "At a time when physicians felt comfortable only with clearly organic disorders, a diagnosis of neurasthenia permitted some to address themselves to less tangible clinical issues and to provide an essentially psychological therapy under a somatic label."[29]

Towards the end of the 19th century, Dr. Silas Weir Mitchell created a therapy called the rest cure, developed to replace lost nerve energy. This therapy was first tested on Civil War soldiers suffering from exhaustion, but became useful for neurasthenic patients suffering from related symptoms. Mitchell's rest cure, Gosling writes, "was devised primarily for fashionable ladies who could afford his high fees and were eager to receive his personal attentions."[30] Mitchell took his rest cure quite seriously; he required his patients to be isolated and in bed. Patients were also fed a high protein diet, turned, massaged, and comforted by a caregiver to build up the depleted nerve force. Patients were not allowed to read, write, or be seen by persons other than the physician and caregiver (typically a trained nurse); patients were dependent on the physician for all aspects of living.[31] Although many patients recovered from their disabling symptoms, some patients did not recover, since the paternalistic nature of the physician-patient relationship clashed with patients' personalities. For example, writer Charlotte Perkins Gilman could not succumb to Mitchell's cure, "with its reliance on enforced boredom to return women to their 'proper place'."[32] Gilman became depressed after her daughter

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[29] Ibid., 25

[30] Gosling, 37

[31] Ibid, 110, 112

[32] Ibid., 111

was born and was advised by her husband to receive Mitchell's "rest cure", which would ultimately change her overly ambitious, career-oriented role as writer to a more subordinate role as housewife. Mitchell believed Gilman's symptoms of depression were caused by her career as a writer, which did not fit the image of a woman during this time. Gilman eventually refused to endure forced isolation, divorced her husband, and continued her writing career. Although the rest cure did not work for everyone, it was beneficial for understanding the need for physical, as well as, psychological treatment, along with a physician-patient relationship. Shorter explains,

> The significance of the rest cure, neurasthenia, and the rise of private clinics supposedly for medical and neurological disease, is that these apparently organicist concepts helped open the way for psychotherapy and broke ground for the insight that certain forms of psychiatric illness may yield to the healing power of the human voice. This is why the rest and isolation cures claim such historical significance: They treated the mind in the context of a one-on-one relationship between doctor and patient. The biological model, as it had evolved by the end of the nineteenth century, was much lacking in any understanding of the mind as the intervening link between brain and behavior.[33]

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[33] Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, (New York: John Wiley and Sons, Inc., 1997),136.

C. The Disappearance of Neurasthenia

Neurasthenia was the most common diagnosed disease in America in the early part of the 20th century. However, several reasons led up to the disappearance of neurasthenia from clinical practice and from the DSM classification system. Gosling writes, "Interestingly enough, although neurasthenia was one of the most common diagnoses made in the late nineteenth century, and still appeared in the last edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II), it was dropped from the DSM-III because no one ever used it! Thus, diagnoses based on more specific diagnostic criteria of symptoms have replaced the generic term *neurasthenia*, but the manifestations have remained the same."[34] One reason neurasthenia disappeared was because clinicians were unable to find the pathological basis of the disease. Also, due to developments in science and medicine, i.e., new theories of disease and supporting biological and psychological evidence, classifications of symptoms became more precise, thus eliminating the need for a label to characterize a wide range of symptoms, at least for clinicians in the Western world.

In China, neurasthenia (shenjing shuairuo) remains a disease label in the *Chinese Classification of Mental Disorders,* second edition (CCMD-2), characterizing physical and mental fatigue, dizziness, headaches, and other symptoms similar to those characterized by Beard. "In many cases, the symptoms would meet the criteria for a DSM-IV Mood or Anxiety Disorder."[35] Because disease labels such as neurasthenia have

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[34] Gosling, 2.

[35] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision (DSM-IV-TR), (Washington, DC: American Psychiatric Association, 2000.), 902.

not entirely disappeared from classification systems and clinical practice, it is questionable whether an increase in the number of disease labels in the Western world, characterizing more precise diagnostic criteria, e.g., psychosomatic disorders, are, in fact, more useful for diagnosing and treating patients.

D. Framing the Conception of Neurasthenia

When looking at neurasthenia through a coherence framework, difficulties arise in finding a coherent fit among the philosophical dimensions of the framework. I first look at neurasthenia as it was understood in America during the early 20th century and develop a framework accordingly to show that neurasthenia was not a myth, but a respectable disease label to characterize symptoms that were experienced by many people during this period. Those who support a biological model of disease may reject this position, since the pathology of neurasthenia was never found. However, as I argued in previous chapters, disease should not be understood solely as a non-normative conception.

The difficulty in understanding neurasthenia arises when accounting for its disappearance in much of the Western world, thus changing the dynamics of the coherence framework. For some, the disappearance of neurasthenia suggests it was not a disease, but a construction for social and political purposes. By adjusting the framework, achieving a new coherent fit among the metaphysical, epistemological, and ethical dimensions, I show this view to be problematic.

In short, I do support the view that neurasthenia was socially and politically *useful* for legitimizing patients' complaints and, for a short time, keeping middle and upper class patients out of the asylums. However, neurasthenia is not a myth. As a nonspecific disease, neurasthenia characterized mental and physical problems affecting patients' health, which required care and treatment. Even though most biological and psychological theories surrounding neurasthenia were erroneous with respect to our current scientific and medical knowledge, e.g., the theory of "nerve energy", what was known was advantageous to clinical practice. Diagnostic and treatment practices improved the health of many patients, partly because physicians understood the importance of understanding the patient as a person - an embodied mind.

Understanding an Early 20th Century American Disease

One critical factor leading up to the classification of neurasthenia, was the recognition of patients' symptoms. Patients' mental and physical problems, which were once ignored or not taken seriously by clinicians (often claiming their patients had an active imagination), were not only recognized, but also characterized under a non-stigmatizing disease label. The recognition and characterization of symptoms led to effective treatment practices and a better understanding of the patient as person; the development and utility of neurasthenia contributed to modifications in (M) metaphysical, (E) epistemological, and (Et) ethical dimensions of mental disease.

Modifying the (M) metaphysical conception of the subject of disease, the subject was no longer viewed merely as a biological entity but viewed as a *person*; the diagnosis of neurasthenia gave clinicians a way to address the biological needs, as well as the psychological needs of their patients. In taking an interest in the psychological needs of patients, clinicians did not require that patients' complaints have a biological basis, thus eliminating many of the problems surrounding diagnosis and treatment practices. For example, under the label of neurasthenia, patients with complaints of vague pains would be taken seriously, rather than characterized as having an active imagination or, worse yet, labeled "insane" and institutionalized. Thus, the metaphysical modifications involving the subject of disease also hinged on (Et) ethical considerations; there was a moral responsibility on the part of clinicians to take their patients' complaints seriously and provide effective care.

Some may argue the neurasthenia label was implemented into clinical diagnostic practices because of social and political needs, such as separating the social classes by keeping the poor in the asylums and the wealthy, working classes out. Such social and political factors surrounding the diagnosis of neurasthenia parallel those surrounding the diagnosis of schizophrenia in the Soviet Union during the 1950's, i.e., intentionally misdiagnosing dissidents to warrant their institutionalization. Some clinicians misused the neurasthenia label, diagnosing only those who could afford treatment (upper and middle classes) as neurasthenic, even though the poor exhibited the same symptoms. However, not all clinicians supported diagnostic and treatment practices involving socio-economic inequalities, and not every poor patient diagnosed with neurasthenia was institutionalized or inadequately treated. Furthermore, unlike Soviet Union psychiatry, the diagnosis of neurasthenia was not explicitly developed for political or social purposes; in part, the neurasthenia label was used to legitimize those symptoms once regarded as imaginary.

The metaphysical modifications also hinge on (E) epistemological factors surrounding what clinicians knew about neurasthenia and about those persons experiencing symptoms characterized by the disease label. Although the pathology of neurasthenia was never discovered, clinicians did know, through the gathering of patients' reports and direct observation of their behaviors, that patients experienced a pattern of mental and physical symptoms, possibly correlated with developments in modern civilization. Such theories, surrounding the nature and cause of this pattern of symptoms, were useful in the development of clinically significant disease labels. The disease label of neurasthenia contributed to a more consistent diagnosis; clinicians, looking at the particular pattern of symptoms their patients exhibited, could determine which disease affected the health of their patients without having to know whether a pathological malfunction or abnormality was present. Knowing the patient experienced a particular pattern of symptoms and having a metaphysical understanding of the patient as an embodied mind contributed to a more holistic approach in the diagnosis, prevention, and treatment of neurasthenia. This illustration appears to provide a better understanding of the conception of neurasthenia as a mental disease. However, moving back and forth between the (M) metaphysical, (E) epistemological, and (Et) ethical dimensions of the coherence framework, taking into account the development of new theories and practices leading to the disappearance of neurasthenia, illustrates a different understanding.

Framing Neurasthenia's Disappearance

After the early 20th century, science and medicine continued to advance, developing new theories surrounding the nature and cause(s) of mental diseases. In developing new theories, classifications of mental diseases became more complex, expanding the number of disease labels to account for more precise characterizations of symptoms and treatment methods. Because neurasthenia characterized such a large number of symptoms, all of which were never experienced by a single patient, it was no longer useful for diagnosing patients, since there were more precise disease labels to use. This is not to say people do not experience mental and physical symptoms today that were experienced by people of the early 20th century. The disappearance of neurasthenia only suggests that our labels have changed for what we characterize as disease due to the fact that clinicians eventually found different patterns of symptoms and etiologies that afforded more effective and differentiated treatments. Neurasthenia encompasses several diseases we have classified in our current systems, suggesting the disease(s) people had were not constructed; it was only the label characterizing them that was. Nevertheless, this changes the dynamics of the coherence framework, affecting how we understand neurasthenia as a mental disease.

(E) Epistemological modifications, i.e., the acquisition of new knowledge about mental diseases, contributed to changes among the other elements of the coherence framework, accounting for the disappearance of neurasthenia from Western clinical practice. With the acquisition of new knowledge about diseases, a need developed for more precise and consistent diagnostic and treatment practices. To effectively meet every patient's physical and psychological needs, clinicians could not rely on old theories and therapies. For example, although Mitchell's rest cure was effective for alleviating discomfort from many of his patients, the rest cure was not effective for all his patients. Charlotte Gilman, for instance, could not benefit from the rest cure because she did not support Mitchell's paternalistic methods, which were heavily influenced by society's expectations and views about women. Thus, (E) epistemological modifications required (Et) ethical and (M) metaphysical modifications. This can be illustrated by the need for patient autonomy. The type of physician-patient relationship required for the diagnosis and treatment of neurasthenia, focusing on patient's best interests without consideration for their autonomy, would not be ethically appropriate for clinical practice today. Because persons are also viewed as autonomous, self-determining, individuals, able to make decisions regarding their medical care and treatment, the physician-patient relationship must reflect this aspect. Although the clinicians of the early 20th century viewed the subject of disease as a psychological and biological person, elements of how the subject ought to be respected, i.e., as an autonomous person, were not considered. Thus modifications of metaphysical, epistemological, and ethical dimensions, such as the ones described, could be traced from the birth of neurasthenia to its disappearance as a useful diagnostic classification. However, such modifications do not suggest that neurasthenia, or the symptoms it characterized, was a myth. At the turn of the 20th century we did not have the language and science we do now, contributing to a *different*, and not necessarily better, understanding of symptoms, their causes and effects, and how they are characterized under disease labels.[36]

The historical significance of neurasthenia should not be overlooked; such a disease label recognized the need for patient care, viewing the patient as a person with biological and psychological needs. Historian Edward Shorter writes, "Neurasthenia, like its grandchildren chronic fatigue syndrome and multiple chemical sensitivities a hundred

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[36] Some of the new diseases that were lumped together under the neurasthenia label are generally those under the categories of mood and anxiety disorders, including chronic fatigue syndrome, postpartum depression, dysthymic disorder, posttraumatic stress disorder, social anxiety disorder, and so on.

years later, served as a bridge between supposedly organic causes and symptoms involving mood and cognition."[37]

Schizophrenia

In 1911 Eugen Bleuler coined the term "schizophrenia". The symptoms of schizophrenia usually include impairment of thinking, hallucinations, delusions, and changes in emotion and behavior that can vary from patient to patient. Patients can also have varying courses of illness and responses to treatment.

Because of the variability in clinical presentation, severity of disease, courses of illness, and response to treatment, physicians and researchers have been unable to determine the exact etiology of schizophrenia. Although the etiology of schizophrenia is not known, considerable knowledge has accumulated about the illness. For instance, it is known that schizophrenia affects the limbic system of the brain. There is also evidence to suggest that schizophrenia is hereditary and that damage to the brain may occur in the early stages of life.[38]

Patients afflicted with the disease not only suffer from its terrifying symptoms but also from the knowledge that schizophrenia is an incurable disease. Generally, it is assumed that schizophrenia only affects adults. However, schizophrenia also occurs in adolescents and children; the prevalence of schizophrenia is estimated to be 50 times greater in adolescents than in children. When an adolescent or child is diagnosed with

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[37] Shorter,130.

[38] Torrey,129.

schizophrenia, parents or guardians often find it difficult to accept that *their* child has been diagnosed with a mental illness. They try to cope by hiding the symptoms, blaming themselves or others for causing the disease, or ignoring the social and medical problems associated with schizophrenia.

Schizophrenia is an illness that causes severe emotional and behavioral symptoms that can make it difficult or impossible for the adolescent or child to function within his or her family or in society. In addition, mental illness can create prejudice and discrimination, as well as social stigma for the patient and the family.

E. Fuller Torrey writes,

> Schizophrenia lurks in the closets, hiding behind euphemisms like 'nervous breakdown' or 'bad case of nerves'. It stands quietly behind lace curtains but nobody bothers to mention it. It is the son who got in trouble in late adolescence and is now thought to be living in Pennsylvania; what they didn't tell us was that he has been committed to the state hospital there. It is the sister who tragically committed suicide because she was plagued by voices and chose not to live with her disease. We hide it, hoping nobody will tell, hoping nobody will find out. It is a stigma.[39]

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[39] Ibid., 5.

One contributing factor why stigmatization is present is that the term "schizophrenia" is often misused. Individuals with schizophrenia are often viewed as someone with two or more distinct personalities. Furthermore, besides having distinct personalities, these personalities are deemed violent or evil. Ming T. Tsuang and Stephen V. Faraone explain, "Sadly this usage of the term can still be found in the seedier corners of the news media, and in particular the tabloid press." Tsuang and Faraone state that individuals with schizophrenia may also be viewed as having 'split personality', "which renders the sufferer incapable of consistent thought or behavior. At this time the term seems to have entered our common vocabulary as a metaphor for indecision, irrationality, or inconsistency."[40] The final way the term is misused is when clinicians use variants of *schizophrenia* inconsistently or indiscriminately. For example, if a patient is experiencing symptoms of depression and/or other mood disorders, the patient may be described as schizophrenic, even though the patient does not meet all the diagnostic criteria.

A. Psychiatric Diagnosis and Treatment

Diagnostic criteria need to be present from two groups, including core symptoms and course criteria. Core symptoms include the presence of massive disruptions in thought, perception, emotion, and motor behavior, occurring for a long period of time during one- month or longer. These massive disruptions may include delusions and

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[40] Tsuang, Ming T. and Stephen V. Faraone. *Schizophrenia: The Facts*. (New York: Oxford University Press, 1997.), 15

hallucinations. Tsuang and Faraone write, “The course criteria require that the time sequence of the symptoms and other aspects of behavior follow a specific pattern. One of these requires that, over a period of time, the patient has shown a decreased ability to function effectively at work, in social relations, or in taking care of himself.” [41] Furthermore, there must be continuous signs of illness for at least six months in order for a diagnosis of schizophrenia to be made. There are also certain exclusion criteria, in which a diagnosis of schizophrenia cannot be made if these criteria are present even if core symptoms and course criteria are present. Tsuang and Faraone state,

> The patient must not have the marked disruptions of mood that would qualify for a mood disorder. Schizophrenia is also excluded if a known physical cause triggered and maintained the disturbance. For example, certain drugs can mimic schizophrenic symptoms. Schizophrenic-like symptoms can also be caused by neurological conditions such as epilepsy or brain tumors.[42]

One of the problems is distinguishing schizophrenia from mood disorders. However when patients appear to experience schizophrenic and affective symptoms, these patients are often diagnosed under the label “schizoaffective”; patients experience severe aberrations of mood, together with massive disruptions of thought, perception, emotion, and so forth. Tsuang and Faraone explain, “Although the two classification

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[41] Ibid., 15.

[42] Ibid., 15.

systems…ICD-10 and DSM-IV give broadly similar definitions of this disorder, the exact relationship between mood disorders and schizophrenia is one of the 'hot potato' debates within psychiatric research."[43]

Although no cure has been found, several biomedical and psychosocial methods of treatment have been used to alleviate symptoms experienced by the patient with schizophrenia. One biomedical method, the use of neuroleptic drugs, were introduced in the 1950's, and have been shown to be affective in treating schizophrenic symptoms at different stages of the course of the disease. Although many people with schizophrenia have benefited from neuroleptic drugs, such as Clozapine and Risperidone, these drugs have serious side effects. The most common of these side effects of these drugs are categorized as extrapyramidal, and include dystonia, akathisia, and pseudo-parkinsonianism.

Another biomedical method to treat schizophrenia is electroconvulsive therapy (ECT), also known as electroshock therapy, which involves the application of an electric current to the brain. This form of treatment is highly controversial, and although it has been proven useful for treating patients with depression, it is not very useful for treating schizophrenia even though it continues to be tested on schizophrenic patients. Psychosocial forms of treatment, including psychotherapy and behavior therapy, are not commonly used without drug therapy. Many psychiatrists believe these psychosocial forms of treatment are not useful, or valuable, for treating schizophrenia. "The American Psychiatric Association Commission on Psychotherapies conducted a major study of this

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[43] Ibid, 20.

subject and concluded that, although useful for many other psychiatric disorders, psychotherapy was not an effective treatment for schizophrenia. Without ruling out its use altogether, it was deemed suitable only as an adjunct to, and not a replacement for, drug treatment."[44]

B. Involuntary Institutionalization

Another way in which schizophrenic patients have been treated is through compulsory or involuntary institutionalization, a common practice during the 18th and 19th centuries. Today clinicians hospitalize patients with schizophrenia against their will if they are a danger to themselves or others and require supervised care and treatment. The involuntary institutionalization of mentally diseased persons, in general, raises several ethical concerns. Tsuang and Faraone write,

> The forcible incarceration of any individual, even in the healing environment of a hospital, necessarily poses serious questions of human rights...several principles are common to all responsible psychiatric regimes. Foremost among these is the principle that, after the safety of the public and the patient, the next most important consideration is the short- and long- term health and happiness of the person suffering from the illness. Last of all comes society's natural desire for basic standards of behaviour. If these

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[44] Ibid, 113.

> principles are applied, the forcible hospitalization of certain schizophrenics seems justified.[45]

Roger Peele and Paul Chodoff consider ethical arguments surrounding institutionalization. Those who believe mental disease is a myth, like Szasz, but understand persons may have problems with living, believe these persons should “not be subjected to involuntary treatment for a non-existent entity.”[46] Those who believe mental disease is not a myth may view involuntary hospitalization and treatment as a misguided psychiatric practice, or a practice that can sometimes be humane and effective so long as the patient is not coerced. Those who support some forms of coercive psychiatric treatments see involuntary hospitalization as a last resort; “society should first work to make psychiatric treatment in clinics and hospitals attractive and accessible before expending any resources on involuntary treatment.”[47]

Peele and Chodoff explain that advocates of involuntary institutionalization and treatment believe “psychiatric disease exists, that psychiatric treatment can be beneficial, that coercion is often humane and effective, and that attractiveness and accessibility cannot always replace the need for coercion.”[48] The need for coercion suggests some mentally diseased persons are incapable of making autonomous decisions on their own

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[45] Ibid., 124.

[46] Roger Peele and Paul Chodoff. “The ethics of involuntary treatment and deinstitutionalization””in *Psychiatric Ethics*, 3rd edition, Sidney Bloch, Paul Chodoff, Stephen A. Green (eds.), (New York: Oxford University Press, 1999.), 430.

[47] Ibid., 430.

[48] Ibid., 430.

and their interests should be only understood and carried out by the clinician. Some clinicians believe mentally diseased persons are child-like, since they exhibit behaviors and are unable to rationalize diagnosis, prognosis, and treatment, similar to a small child, thus "affording a justification for *parens patriae* criteria for involuntary hospitalization."[49]

Abuses of involuntary treatment and hospitalization come in two forms: (1) involuntary hospitalization of persons who are not mentally diseased, or who do not meet the diagnostic criteria, and (2) mistreatment during hospitalization. In chapter 2, I showed that Soviet psychiatry is one example of involuntary hospitalization of persons who are not mentally diseased. Paul Chodoff writes, "The purpose of the Soviet state in sponsoring and orchestrating this misuse of psychiatry was to discredit legitimate dissent by labeling it as insanity."[50] Psychiatrists were working for the interests of society and arguably not primarily for the interests of the patient. Professor Andrei Snezhnevsky created his own diagnostic system for diagnosing schizophrenia; His system made it easy to classify dissenters as suffering illnesses such as 'sluggish schizophrenia', "a diagnosis not disqualified by 'seeming normality' and 'absence of symptoms'."[51] The victims were primarily political dissenters, but also included nationalists, religious believers, and anyone who was uncooperative. Chodoff states, "Notwithstanding the increasingly vehement protest by psychiatrists throughout the world, particularly under the aegis of

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[49] Ibid., 431.

[50] Chodoff, Paul. "Misuse and Abuse of Psychiatry: An Overview"in *Psychiatric Ethics*, 3rd edition, edited by Sidney Bloch, Paul Chodoff, Stephen A. Green.(New York: Oxford University Press, 1999.), 58.

[51] Ibid., 58.

the World Psychiatric Association, the perversion continued, involving thousands of victims, until slowly and finally sputtering to a halt as Communism collapsed in the former Soviet Union."[52]

Because of wrongful or unethical practices of diagnosing and treating patients with schizophrenia, Szasz and his followers questioned the reality of schizophrenia. In other words, although schizophrenia has no identifiable etiology, suggesting it is not a disease, the classification, diagnostic and treatment abuses gave further reason to believe schizophrenia was a myth – a construction for social and political purposes. Although many persons experience disturbing symptoms such as hallucinations and delusions, Szasz suggests these "symptoms" are unattributable to a disease.

C. The Myth of Schizophrenia

Szasz states,

> Schizophrenia remains the paradigmatic metaphoric illness of modernity; a non-illness – generated by our bafflement by what the Other qua Madman says, authoritatively declared to be a disease (justifying his involuntary hospitalization and treatment). So important schizophrenia has become – not only in psychiatry but in modern society as a whole- that perhaps never before in history have so many educated people wasted so much time and money as

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[52] Ibid, 59.

> have diverse professionals squandered on studying this nonexistent illness.[53]

One of the characteristics of schizophrenia is abnormal speech. Although Szasz accepts the fact that with brain damage, such in the case of a person having a stroke, alterations of speech can be attributed to a disease (of the brain). However, he believes the abnormal speech of a patient with schizophrenia cannot be attributed to a disease in the brain. Instead he provides a set of characteristics which distinguish the patient with brain damage from the person with schizophrenia. Szasz states that the schizophrenic person "has no trouble expressing himself…he is not embarrassed by his speech behavior; on the contrary, he treats it as if it were perfectly normal."[54] Szasz dismisses the possibility that the schizophrenic person's alterations in speech is due to some malfunction in the brain, and suggests that this "abnormal" speech, incomprehensible to the listener, is just an unconventional way of verbally expressing oneself. "The leap from aberrant discourse to aberrant brain function – that is, the proposition that a disorder of language is *ipso facto* a disease of the brain – is plainly fallicious."[55]

Ssasz also views another characteristic of schizophrenia, hearing voices, as a psychiatric invention. He claims that the person "hears" speech, not voices. Hence, it is an error to accept the assertion that he hears voices and to define the efforts to suppress

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[53] Szasz, Thomas, *The Meaning of Mind: Language, Morality and Neuroscience*, (New York: Syracuse University Press, 1996), 121.

[54] Ibid., 122.

[55] Ibid., 123.

the voices as a "treatment." It would be more useful, for both the hallucinating subject and his interlocutor, to ask the subject about the identity, characteristics, and motives of the agent who is "speaking" to him (for example, his gender, accent or dialect, motives, relationship to the listener, and so forth).[56]

If a person really hears voices then, says Szasz, "the cerebral-physiological processes accompanying the hallucinating person's experience would be similar to those accompanying normal hearing."[57] Through neuroimaging techniques, researchers have shown that the area of the brain activated, is the area of speech (Broca's area) and not hearing (Wericke's area). Szasz explains that given this scientific evidence, neuroscientists do not suggest the hallucinating person is disavowing his thoughts, but that this person has an actual brain disease, or a disorganization or disorder of inner speech (speech that is only accessible to the individual). Ssasz, however, believes this interpretation is incorrect: "I interpret it as a manifestation of disavowed self-conversation, projected onto imaginary "voices." This suggestion is supported not only by the neuroimaging evidence cited, but also by the familiar clinical observation that when a (hearing) person who has auditory hallucinations is engaged in oral activity, such as eating or speaking, his imaginary voices become less noticeable or stop altogether."[58]

Szasz believes that not only does the person produce the voices he or she hears, suggesting this is an intentional act, but also the person prefers the company of his or her voice compared to other human voices, because such persons are not eager to voluntarily

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[56] Ibid., 125.

[57] Ibid., 126.

[58] Ibid., 127.

take antipsychotic drugs.[59] Furthermore, Szasz compares the schizophrenic patient experiencing hallucinations to a child, since both, he claims, do not take responsibility for their actions and feel the need to blame something or someone.

Szasz writes,

> An adult who blames his own bad thoughts on "voices" resembles a young child who blames his misconduct on an innocent sibling or imaginary stranger. The adult world easily sees through the child's naïve stratagem, perhaps because children are not subject to the same legal punishments as adults. In contrast, the adult world, represented by the combined prestige of law, psychiatry, and the media, feels compelled to accept the "psychotic" adult's similar stratagem – that he actually hears voices which he is powerless to resist – to avoid having to treat the offending person as a responsible moral agent.[60]

Besides viewing the schizophrenic person as a child, Szasz also believes this person is a liar, and that what he or she experiences are not symptoms of a disease but a clever way to hide personal confusions and deficiencies. Szasz states, "I believe viewing the schizophrenic as a liar would advance our understanding of schizophrenia.

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[59] Ibid., 131.

[60] Ibid., 131.

What does he lie about? Principally about his own anxieties, bewilderment, confusions, deficiencies, and self-deceptions. He pretends that he is not confused, impotent, and insignificant; he is confident, powerful, and supremely significant."[61]

D. Framing Schizophrenia as a Mental Disease

Realizing the controversial nature of schizophrenia as demonstrated by views held by clinicians, patients, and their families who believe it is a disease, and those, like Szasz, who believe it is a myth, we need to develop a better understanding of schizophrenia. To do this, we need to look at the conception of mental disease in relation to the person with schizophrenia, as well as, the clinical practices surrounding the identification and treatment of the disease as we work back and forth between the metaphysical, epistemological, and ethical dimensions of the coherence framework. In the following illustration I put the coherence framework to motion, explaining how equilibrium is achieved, lost, and regained.

Equilibrium

Historically clinicians and researchers thought that schizophrenia, like many mental diseases, was caused by a disruption in psychological development. In looking at (M) metaphysical considerations, clinicians identified the subject of schizophrenia as the individual who appeared to be unaware of his or her environment, and who, at times, displayed unusual behaviors such as talking to imaginary people. Clinicians could not

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[61] Ibid., 130.

identify a physical abnormality, or disease entity, in their patients who displayed such abnormal behaviors. This (M) metaphysical consideration supports and is supported by certain (E) epistemological considerations. For example, to identify subjects of schizophrenia, clinicians had to rely on their knowledge about abnormal behavior (how persons do not normally behave and whether such behaviors impair cognitive functions such as reasoning) and on patient reports, which gave descriptions of their experiences of abnormal and disturbing psychological symptoms. Because there was no identifiable etiology, to know that subjects of schizophrenia were diseased rather than eccentric, clinicians set out to understand what it was like from the inside to be the patient. However, to know what it was like to be the patient with schizophrenia was a difficult task for clinicians, since many patients did not believe their behaviors, thoughts, and feelings were abnormal, and thus, did not report their experience as symptoms (e.g., the patient believing his or her hallucinations to be real does not necessarily report the hallucination as a disturbing symptom). So although clinicians could not fully understand what it was like to be the patient with schizophrenia, an understanding developed by observing patients outside of a clinical setting; clinicians observed patients in their own home and work environments. Part of understanding what it was like to be the patient involved looking at how their behaviors, thoughts, and feelings affected their daily living and interpersonal relationships and how the environment may have affected or caused patients' abnormal and disturbing symptoms. Many theories surrounding the causes of schizophrenia developed based on clinicians' observations of patients and their environment.

One theory that was based on clinical observation of patients and their families was the theory of the schizophrenogenic mother. This theory states that, through their poor parenting skills, mothers increase the likelihood of their children developing schizophrenia. Tsuang and Faraone write, "Such mothers, it is claimed, send out contradictory and confusing signals regarding correct behaviour; convey and hence encourage inconsistent emotional responses; are overprotective of their children and insensitive to their psychological and affective needs."[62] Because theories such as this one were able to explain why persons experienced and displayed abnormal behaviors, which affected daily living and interpersonal relationships, clinicians became more confidant that schizophrenia was a disease rather than a mere eccentricity. Thus, from a (E) epistemological perspective, or what clinicians knew about their patients with schizophrenia and the causes of schizophrenia, an equilibrium was established with the (M) metaphysical consideration that what schizophrenia is, is a disease. Because schizophrenia is understood as a disease and clinicians know patients with this disease experience disturbing symptoms, these (M) metaphysical and (E) epistemological considerations support and are supported by certain (Et) considerations; clinicians have a moral imperative to accurately diagnose and treat their patients with schizophrenia to eliminate or reduce disturbing symptoms. To ensure that patients are accurately diagnosed and are not harmed by a misdiagnosis, clinicians need to develop consistent criteria based on their knowledge of schizophrenia and of the subject of schizophrenia, thus suggesting (Et) considerations, e.g, to do no harm by avoiding misdiagnosis, support

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[62] Tsuang and Faraone, 60.

and are supported by (E) epistemological considerations, e.g., the development of consistent and accurate criteria based on clinical knowledge. However, (Et) considerations also need to support and be supported by (M) metaphysical considerations. For example, the moral imperative to accurately diagnose and treat patients with schizophrenia depends on whether patients being diagnosed and treated have a disease rather than an eccentricity. If patients who are eccentric are treated with pharmaceuticals, for instance, thus altering the physical and psychological aspects of the person, then these patients are being wrongfully treated.

From this illustration, one can see the movement between the metaphysical and epistemological elements of the coherence framework. The (M) metaphysical consideration, identifying what is the subject of disease, mutually supports (E) epistemological considerations, or what clinicians know about their patients with schizophrenia, which contributes to theories about the possible causes for schizophrenia. These (E) epistemological considerations, in turn, support (M) by identifying what schizophrenia is, i.e., a disease, which is confirmed by clinical knowledge of disturbed patients and reasons why these disturbances exist. Certain (Et) ethical considerations also support and are supported by (M) metaphysical considerations; without a better understanding of what schizophrenia is, who is the subject, and what it is like to be the subject, clinical diagnostic and treatment practices may not be beneficial or even harmful to the patient (e.g., a poor understanding of what it is like to be the subject, assuming the subject is unable to make decisions, restricts his or her autonomy). (E) Epistemological considerations support and are supported by (Et) considerations; without accurate and reliable criteria based on clinical knowledge about schizophrenia, wrongful diagnosis or misdiagnosis can occur, thus possibly harming the patient. And, without realizing what may be harmful to the patient, criteria may not be established to avoid such harm.

Equilibrium Lost

Although parenting does have a significant effect on a child's psychological development and clinicians may have observed *some* abnormal parent-child relationships, the theory of the schizophrenogenic mother is ethically and epistemologically problematic. Parents, feeling responsible for causing schizophrenia, blame themselves and suffer from guilt, anxiety, and depression. Tsuang and Faraone explain "Although it is true that some families appear to include parents whose attitude and behavior did little to help their schizophrenic offspring, we feel that it is irresponsible to extrapolate from those observations an entire theory that blames parents for the development of the illness in their children."[63] Other theories similar to this one have suggested that the schizophrenic or non-schizophrenic parent is solely responsible for causing harm to his or her child, i.e., schizophrenia, by passing on "bad genes" or by poor parenting skills. These theories not only remain inconclusive but also raise ethical concerns involving the wrongful blaming of parents, especially since there is no conclusive evidence pointing to parental causes. Thus, (Et) Ethical considerations in the framework do not mutually support and are not supported by (M) metaphysical and (E) epistemological considerations. Because of the ethical consequences of this theory, we need to reject this theory. But, by rejecting this theory, certain metaphysical and epistemological

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[63] Ibid., 61.

considerations may require some adjustments. As I previously stated, theories such as the schizophregenic mother theory helped clinicians confirm their belief that schizophrenia was a disease (these theories explained what caused the disease). Acquiring knowledge about the cause(s) of schizophrenia was useful for understanding schizophrenia and the subject of schizophrenia, especially since there was no known etiology. However, because the theory is rejected, knowledge about schizophrenia and the subject of schizophrenia becomes limited (clinicians only know what the subject of schizophrenia experiences based on observations and patient reports of symptoms), and, with this limited knowledge, one may argue that we cannot sufficiently prove schizophrenia is a disease. Thus, by rejecting the schizophrogenic mother theory and gaining new knowledge about schizophrenia and the subject of schizophrenia, we begin working back and forth between the elements of the framework once again to regain equilibrium.

Equilibrium Regained?

Current theories of schizophrenia suggest that it is a neurodevelopmental disorder, possibly due to genetic and/or environmental factors, where the patient's brain does not properly develop. Theories such as this one may help researchers try to understand what schizophrenia is, and how to eventually prevent its occurrence. Scientific theories are important but only to the extent that progress is being made in detecting the unknown etiology of schizophrenia, possibly affecting diagnostic and treatment practices. These theories, which remain inconclusive, do not put the patient at ease by giving him or her hope or providing the means to alleviate physical and/or psychological pain and suffering. Clinicians, then are only partially concerned with these theories, and are more interested in making accurate and reliable diagnoses and alleviating the disturbing symptoms experienced by the patient.

From a (M) metaphysical perspective, the conception of disease and the subject of disease need to be considered. Because it is unclear whether one can identify what *it is* that consumes the life of the patient who experiences a vast array of symptoms labeled as schizophrenia, part of our metaphysical picture is incomplete. Although some clinicians claim to know what it is like to be the patient with schizophrenia, it is unclear whether or not their patients do, in fact, have a disease. But, as many clinicians point out, even though there is a history of abuse, i.e. constructing diseases for moral, social, and political purposes, e.g. Soviet psychiatry, purposeful and non-purposeful misdiagnosis, forced institutionalization, etc., schizophrenia as a disease label characterizes an array of real symptoms experienced by the person – the subject of disease. To deny the fact that thousands of individuals have experienced similar patterns of symptoms including hallucinations and delusions is to disregard these individuals as persons who have clinical and social needs, regardless of the fact that no one knows completely what schizophrenia *is*. And, even though theorists like Szasz view schizophrenia as a myth, individuals experiencing disturbing symptoms characterized by schizophrenia are neither myths nor liars by hiding their personal confusions and deficiencies.

From (Et) an ethical perspective, if clinicians or others do not believe individuals are truly experiencing symptoms such as delusions or hallucinations, they are not treating them as *persons*. Furthermore, if clinicians assume that what their patients experience are not real and fail to help them, they may be violating ethical principles such as the principle of beneficence. Such ethical considerations depend on what the clinician knows about his or her patient and the development of a trustful and respectful therapeutic relationship. If there is no trust or respect between clinician and patient, the therapeutic relationship breaks down, impairing communication and making clinical practice difficult and unrewarding.

In addition to the subject of disease, the conception of disease is an important (M) metaphysical consideration. Even though schizophrenia has no known etiology, this is not to say that schizophrenia is not a disease. If we are to look at schizophrenia from a Boorsian perspective, it is clear that persons with schizophrenia are "below species typical functioning". In other words, the symptoms experienced by the person with schizophrenia affect thoughts, feelings, and behaviors, making the patient unable to live free of psychosocial disturbances. For example, when a person with schizophrenia becomes paranoid (perhaps thinking someone is out to harm him or her) he or she is unable to live without anxiety and fear. If a person is unable to live a "normal" life, or a life relatively free of persistent or chronic mental and/or physical disturbances, this suggests he or she may have a disease and should seek professional help.

The (M) metaphysical dimensions of the framework, i.e., understanding schizophrenia as a disease and those with schizophrenia as subjects of disease, mutually support (E) epistemological dimensions in determining how we know schizophrenia is a disease and whether or not patients with schizophrenia are diseased. In looking at (E) epistemological considerations, it is important to understand what the clinician knows about schizophrenia and his or her patient. Also, we need to consider what it is like to be the patient – the person with schizophrenia. A patient may *know* if something is a disease if persistent or chronic symptoms, which may incapacitate him or her, are present. If patients are unaware of their symptoms, e.g., they do not realize their hallucinations are not real images or sounds, then friends and family play an important role in understanding the disease and the person with the disease, e.g., they may be able to detect whether their loved one displays abnormal behaviors, and determine if their loved one needs medical help.

In looking at what it is like to be the patient, the clinician knows that the patient wants to live a normal life without emotional or psychological disturbances, and without drawing attention to him or herself with a stigmatizing disease label. In order to live a so-called normal life the patient must be properly diagnosed and undergo treatment, willingly or forcibly. The clinician faces a difficult challenge in diagnosing and treating his or her patient. Although the DSM provides useful guidelines in diagnosing patients, the clinician must use his or her own experiences and clinical expertise in determining if the patient's complaints are characteristic of specific disease criteria, i.e., schizophrenia.

The above epistemological considerations mutually support and are supported by certain (Et) ethical considerations. For example, when a clinician diagnoses a patient with schizophrenia he or she should be aware of the patient's values and try to work through any problems experienced during the course of treatment. For instance, some patients with schizophrenia may not like to take prescribed antipsychotic drugs because they do not "feel like themselves." When a patient does not take the prescribed medication, he or she may be viewed as irresponsible or not wanting the help provided. Clinicians need to understand that patients need to exert some autonomous control over

their lives; they do not want to be controlled by their treatments. One way is to help patients understand their disease and the importance of their treatment regimen, as well as maintain some control over their lives.

Further ethical problems may arise when patients cannot comprehend the diagnosis and treatment plans and are incapable of making important medical decisions. When patients have no decision-making capacity, another has to make the decisions on the patient's behalf, possibly forcing necessary treatments and hospitalization. Making decisions on a patient's behalf requires reflection on the above (M) metaphysical considerations, namely to understand the patient as an embodied mind, a person with interests and values. Without understanding the biopsychosocial needs of the patient, he or she may not receive adequate care and treatment, and we fail to develop a better understanding of schizophrenia. Such considerations also hinge on (E) epistemological ones. For example, in order to safeguard against purposeful or non-purposeful misdiagnosis and wrongful treatment, clinicians need to confirm their diagnosis and provide follow-up care with what they know about the disease and the person with the disease.

Although we do not have a clear picture as to what is schizophrenia or even what it is like to be the patient with schizophrenia, because thousands of people experience disturbing psychological symptoms, which are sometimes alleviated through psychiatric interventions (but not always), it would seem as though schizophrenia is a disease, based on the best possible fit achieved among the philosophical elements of the framework.

CHAPTER 6

LESSONS AND LIMITATIONS

Lessons

The novelty of this project began when I introduced a method, similar to wide reflective equilibrium, for developing a better understanding of mental disease in which certain relevant considerations must, in light of each other, cohere as a unified whole. After I established which philosophical considerations were to be placed in the framework, including metaphysical, epistemological, and ethical considerations, I then worked back and forth between each element to develop a better, comprehensive understanding of mental disease through the dialectical interplay among each of the elements. Illustrations, including autism, homosexuality, neurasthenia, and schizophrenia were used to demonstrate how coherence could be achieved when new, unconsidered, or problematic cases or situations arise.

Our current knowledge of medical science, technology, and society is useful for answering many of the metaphysical, epistemological, and ethical questions related to mental disease. But, because new theories and discoveries may develop and replace old ones (as illustrated by the example of neurasthenia), it is important to account for these changes and modify the framework, if necessary, by working back and forth between elements once again, restoring a "fit" based on our new knowledge.

As demonstrated by the illustrations of homosexuality, neurasthenia, and schizophrenia, to achieve a better understanding, descriptions, characterizations, and classifications of mental disease must reflect not only clinical and scientific observations of mental disease, but should also reflect patients' biopsychosocial needs. Without a better understanding, patients will be mistreated clinically and/or socially, and those, such as caregivers and families, may be wrongfully blamed for causing the disease, or blamed for not effectively helping or developing meaningful relationships with the patient. Furthermore, without a better understanding, clinicians and other health care professionals will not be able to develop accurate and reliable classification systems, diagnostic and treatment practices, and trustful and respectful therapeutic relationships with their patients.

Limitations

To challenge the methodology and usefulness of the coherence framework one may ask, "Can we achieve a better understanding of mental disease based on just one element of the framework, such as the metaphysical element?" "Why do we need to work back and forth between other elements in order to achieve a better understanding of mental disease?"

If we were to understand mental disease based on one element of the framework, this would suggest that a belief or set of beliefs provides a foundation for all others. One problem with this is that it becomes unclear as to which beliefs about mental disease would serve as foundational beliefs. Furthermore, even if there was some kind of algorithm to determine which beliefs were to serve as foundational ones, they would not necessarily reflect what we currently understand or know about mental disease. For example, if we were to understand mental disease metaphysically, the epistemic and ethical questions and beliefs surrounding mental disease may change, but the ontological status of mental disease, serving as the fixated point or foundation for all other beliefs surrounding mental disease, does not change. In the coherence framework, on the other hand, there is no sacrosanct starting point or foundation to work from; we begin with what we know and our beliefs become justified if they mutually support and are supported by the other beliefs in a given set.

One may ask, "Can this coherence method really work?" "Do we really develop a better understanding of mental disease when there are so many questions and considerations to examine?" "How many situations, theories, and judgments do we need to look at before we can fully understand mental disease?" In answering the first question, the methodology works, and works well, because it helps us understand the knowledge we have and adjusts when knowledge, beliefs, or phenomena about the world changes. Our understanding of mental disease rests on what we currently know about general conceptions of health and disease, the subject of disease (the patient as person), the ethical problems which may arise when we do not have a proper understanding, and what is needed to accurately and reliably diagnose and treat patients. As we gain further knowledge, more questions and situations may arise. We are not required to account for all the knowledge that exists in the world about mental disease in order to achieve coherence. Nielsen writes,

> There is no rationalistic belief that if we just try hard enough for a very long time, we will achieve reflective equilibrium and discover some underlying structure revealing what the truth about morality really is. There is no belief at all – even as a heuristic ideal – that if we apply

> this procedure long enough, diligently enough, intellectually enough, we will finally have some approximation of the one true morality.[1]

The purpose of the coherence framework is not to find the ultimate truth or *the* answer. In other words, we are not going to achieve the single *best* for all time understanding of disease by achieving coherence among metaphysical, epistemological, and ethical considerations. We are only going to achieve a *better* understanding of mental disease, knowing that we are likely going to have to modify our understanding as the world changes and we gain new knowledge.

A. Competing Frameworks

A possible limitation for the coherence framework is when competing frameworks exist. Three different perspectives may arise when looking at conceptions of disease, including clinical practice (diagnosis and treatment of mental disease), clinical research with therapeutic objectives (research designed for clinical trials to improve diagnostic and treatment practices), and basic scientific research with non-therapeutic objectives (research designed to collect information and understand disease on a micro level; researchers are not concerned with individual persons, only general theories).

My framework works well when looking at clinical practice but can it work well from these other perspectives? What if another competing framework develops based on

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[1] Nielson, "Philosophy Within the Limits of Wide Reflective Equilibrium Alone," 26

basic scientific knowledge rather than clinical knowledge? In my framework I do consider scientific theories surrounding mental disease, but these theories are only one of many aspects, which give us a better *clinical* understanding of mental disease, including patients who are diagnosed with mental diseases. Although scientists do not work with patients, some of the goals they have is to improve and develop theories addressing clinical needs, e.g., improving drug efficacy to reduce or eliminate side effects experienced by patients. There may be overlapping beliefs and knowledge about mental disease. If this is the case, then perhaps a single coherence framework could be constructed to encompass the various competing frameworks involving mental disease. Nielsen writes,

> Surely that would be a reason to expect, as Rawls in fact does, many competing reflective equilibria. They compete, and usefully so, but in seeking wide reflective equilibria, we seek equilibria which would, among other things, appeal to a general social society, theory of moral development, theory of the role of morality in society, and theory of human nature, as well as to a wide range of factual considerations. With such varied things being appealed to, we have ways of coherently discussing, being through and through holistic, the comparative adequacy of different reflective equilibria.[2]

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[2] Ibid., 29.

Although a single coherence framework may show common beliefs and knowledge held by medical and scientific communities, it may not be useful for all practical concerns. There are different practical concerns that call for different frameworks. My coherence framework is designed to understand mental disease from a therapeutic perspective, i.e., the clinician and patient's point of view; this framework may not be useful for understanding the epistemic implications of mental disease from a non-therapeutic perspective. A more useful framework may focus on the metaphysical, epistemological, and ethical considerations from the perspectives of researchers rather than clinicians. For example, researchers have an interest in the reliability and accuracy of their scientific data; clinicians on the other hand have an interest in the reliability and accuracy of their diagnostic and treatment practices. When their knowledge is unreliable or inaccurate, different ethical consequences arise, e.g., for the clinician, the patient does not get treated; for the researcher, an experiment needs to be repeated or the experimental drug is rejected and a new one becomes the focus of investigation. Also clinicians and scientists may have different criteria for knowledge or certainty; scientists may be more stringent because they do not have to respond to the demands of clinical practice, especially in the treatment of persons, and the amelioration of disease. Even though a comprehensive understanding of mental disease may be achieved using one framework, it may be more practical to develop different frameworks to address different practical concerns, which may not be raised in a single, broadly construed framework.

B. Conflicting Frameworks

When frameworks *compete*, different perspectives surrounding a situation or concept exists, e.g., schizophrenia is viewed as a disease from two perspectives: clinical and scientific perspectives. We can find similarities among the competing frameworks and develop a single framework, e.g., incorporating clinical practice, clinical research, and scientific research into one framework, or we can keep these different frameworks as they are and use them to address different practical concerns. When frameworks *conflict*, on the other hand, different beliefs rather than perspectives surrounding a situation or concept exists, e.g., schizophrenia is viewed as a disease by the APA and viewed as a myth by Thomas Szasz.

If there are two conflicting frameworks, how do we determine which framework, if any, produces the best results for understanding mental disease, or whether, for example, if a particular condition is a disease? In some cases, frameworks conflict because we mistakenly interpreted the wrong information, did not collect enough factual evidence, or theories changed without our knowledge. In these cases, we can admit our mistakes and reject one of the conflicting frameworks in light of new knowledge, or reject both existing frameworks and make modifications to account for this new information. However, not all conflicts between frameworks may be resolved in this way. For example, in the case of neurasthenia, although I concluded that neurasthenia was a disease, it is no longer a useful classification for Western clinicians. However, in China neurasthenia is a classified disease in current diagnostic systems. Looking at the disease "neurasthenia" two conflicting frameworks exist – one which views neurasthenia as a disease and one that does not.

When there are two conflicting frameworks such in the case of neurasthenia, we can compare the two frameworks to see if a compromise could be made (elements common to both frameworks need to be modified to achieve a new "fit"). However, achieving a fit may not be possible. Conflicting frameworks may reveal puzzling claims about neurasthenia where a compromise cannot be made. The conflict remains unresolved until new information, e.g., theories about neurasthenia in China, arises and modifications are made within the framework, e.g., neurasthenia is no longer viewed as a useful classification in Chinese psychiatry. The coherence framework does not guarantee that every time we compare conflicting frameworks that we will be able to come up with an answer or compromise when conflict arises. If we cannot reject or compromise conflicting frameworks, we accept a kind of relativism, possibly just for a time until new information develops. Therefore, in China neurasthenia is apparently a useful disease label for characterizing, diagnosing, and treating patients. In the United States neurasthenia is no longer a useful disease label. We need to accept these two different beliefs, since the implications of compromise or rejection of one of the frameworks may be detrimental to clinical practice. For example, if we were to eliminate neurasthenia from China's classification system and from clinical practice without reason, telling clinicians not to diagnose their patients with neurasthenia, patients who suffer from the pattern of symptoms characterized by neurasthenia may not be treated the same way, thus possibly compromising patients' biopsychosocial needs. Weighing the benefits of keeping the framework, i.e., meeting patient's needs, versus the burdens, i.e., different beliefs surrounding neurasthenia, suggests that, in some cases, we ought to respect different frameworks even though they conflict with our own.

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