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From the Editor

This issue of the Bulletin follows a format that we have successfully used before—a target piece with commentaries and a response by the authors. As with previous symposia, this one has generated lively and informative discussion. For that we thank both our authors and our commentators.

In this symposium, the commentaries have developed in a variety of directions, raising questions that are at times related to, but not at the heart of, the target article. That is of course all to the good, as the questions all involve the conceptual status of psychiatry and mental illness. Stated in other terms, I might say that you can't analyze anti-psychiatry without analyzing psychiatry, and that's what we have in the commentaries and responses.

With their target paper, "Getting it from Both Sides: Foundational and Antifoundational Critiques of Psychiatry," the authors aim to divide and analyze the variety of anti-psychiatries and anti-psychiatrists into two related pairs: on the one hand logical positivism and postmodernism, and in a broader way philosophical foundationalism and philosophical antifoundationalism. They view logical positivism as a paradigmatic example of foundationalism and postmodernism as a paradigmatic example of antifoundationalism.

In an atmosphere of general appreciation, the commentators offer notes of agreement, expansion, and at times disagreement. Cerullo is in strong agreement with the analysis but feels it could be strengthened by attending to contemporary variants of anti-psychiatry: e.g., Kramer in his early work, Healy, Elliot, and the President's Council on Bioethics. In tune with Cerullo's remarks, It is a misfortune of timing—for both the authors and the commentators— that Marcia Angel's attacks on psychiatry in the New York Review of Books were published after these pieces were written.

One complaint running through some of the commentaries is that the authors, in their critiques of the various anti-psychiatrists, are rather silent about their own position in this discussion. Lewis suggests that they "have a philosophy that combines foundationalist facts with antifoundationalist values." He is probably right in that assumption. The authors suggest as much in the "Facts and Values" section of their paper, and it might have useful for them to be explicit about it.

Another issue that emerges in the commentaries is the value of the rather orthogonal foundationalist/antifoundationalist division—whether it is a productive

(Continued on page 39)

President's Column

Lately I have been thinking about what I know and on what basis I can know it. In particular, I'm thinking of a woman I have seen for many years: I'll call her Greta. Greta has a long history of major depressive disorder with seasonal recurrences that generally respond well to antidepressants. I have observed avoidant, dependent, and histrionic characteristics, and family members have described how these personality features have kept her from pursuing some of her life goals. Still, when she is euthymic, she is indeed a happy and well-adjusted person, with a career, and family and friends who love her.

A year ago her husband passed away, and what I have observed in Greta since bewilders me. She grieved, as would be expected, but after six months a number of other changes emerged. Now in her 80s, she developed what looked like her usual depressive syndrome – apathy, anhedonia, paucity of thought, anergia, hypersomnia, and passive suicidal thinking without a plan of action or real intention. At the risk of overpathologizing, I attributed this mood deterioration to bereavement, although I did not object to the antidepressant her internist prescribed. Over the next months, Greta became increasingly confused and overwhelmed, but continued to tend to her household affairs, and maintain her closest relationships. Her therapist noticed that she had missed a number of appointments, and learned that she had stopped paying her bills, recommended that Greta see a neurologist to rule out cognitive changes. The MRI showed diffuse brain atrophy advanced for Greta's age. Neuropsychological testing confirmed a diagnosis of mild cognitive impairment. Several months later Greta sustained a fall, and the emergency room evaluation showed considerable alcohol intoxication, which Greta dismissed as irrelevant. Since she now lives alone, no one can confirm how much or how regularly she uses intoxicants.

I find that I don't know how to assess the quality of these data, or how to use them meaningfully. Is this bereavement or depression, and does it matter what we call her mood changes at this point? If she is depressed, what role did alcohol use and brain atrophy play in its development or progression, and over what period of time? Should I worry about other drugs of abuse? How do I understand her cognitive changes in light of the grief/depression, which could have influenced the effort Greta made in the ostensibly objective neuropsychological tests. And what to do with the most objective test, the MRI, which shows no focal anomalies, but also provides no general schema for understanding the other clinical features of

(Continued on page 38)

Symposium

Getting It from Both Sides: Foundational and Anti-Foundational Critiques of Psychiatry

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(Follwing the format of other symposia published in the Bulletin, this symposium will take the form of a target paper by our three authors, followed by commentaries and a response to commentaries. Let me thank Ron Pies, Sairah Thommi, and Nassir Ghaemi, as well as all of our commentators, for their efforts in this exercise.

JP)

Introduction

Modern-day psychiatry has been the target of numerous social, philosophical and scientific critiques over the past century, sometimes lumped together as manifestations of "anti-psychiatry." The aim of the present paper is to place the critics of psychiatric theory and practice in the broader framework of two philosophical traditions: *logical positivism* and *post-modernism*. Even more broadly, we want to distinguish two "meta-categories" of philosophical discourse, which we call "Foundational" and "Anti-Foundational." To oversimplify greatly, logical positivism may be considered a subset of foundational philosophies; and post-modernism, a subset of anti-foundational philosophies. We make the latter claim, fully aware that the term "post-modernism" is subject to many interpretations; is sometimes considered vague to the point of meaninglessness; and is, in some ways, more a *literary and cultural attitude* than a well-articulated philosophical position. Nevertheless, as a particular subtype of anti-foundational philosophy, post-modernism remains a useful heuristic term in understanding various critiques of psychiatry.

The burden of this paper will be to outline the historical roots of foundational and anti-foundational philosophies; describe how these philosophies have provided the basis for a "double-barreled" assault on modern-day psychiatry; and finally, to adumbrate very briefly why both kinds of attacks on psychiatry are generally unfounded. First, however, we need to provide at least a notional idea of what the term "antipsychiatry" encompasses.

A Brief Typology of Anti-pychiatry and an Apologia

As Edward Shorter's analysis suggests, the construct of "anti-psychiatry" is, at best, polymorphous; and at worst, simply incoherent. Nonetheless, Shorter's synopsis of the "Antipsychiatry Movement" serves as a useful provisional definition of the term:

> Early in the 1960s, as part of the general intellectual tumult of the time, a protest movement arose against psychiatry. Members of the movement were by no means all in agreement about doctrine; some argued that there was no such thing as psychiatric illness; others that adverse sociocultural conditions exposed members of marginalized groups to political oppression conducted under the guise of medical diagnosis; still others that treating mental patients against their will was unethical, and that electroconvulsive therapy was brain-destroying rather than therapeutic. This grab-bag of diverse claims and objectives came together under the banner 'antipsychiatry'. (Shorter 2005, p. 22)

Shorter goes on to name several prominent critics of psychiatry, under the rubric of antipsychiatry, including Erving M. Goffman, Michel Foucault, Franco Basaglia, and Ronald D. Laing. However, Shorter insists that "…the credit for launching antipsychiatry among a mass audience goes to [Thomas] Szasz" (Shorter 2005, p. 22).

To be sure, the voluminous critiques from Prof. Szasz—beginning with *The Myth of Mental Illness* in 1961—have often been considered part of the "antipsychiatry movement." However, Szasz has clearly and repeatedly rejected this label. Szasz himself employs the term "anti-psychiatry" very narrowly, as a label for the position of David Cooper (1931-86) and R.D. Laing (1927-89). Szasz argues that these individuals continued to use "...coercions and excuses based on psychiatric authority and power" (Szasz 2009, p. ix). Thus, for Szasz, "antipsychiatry" is merely another type of psychiatry. He avers that "...for more than half a century, I have consistently asserted two simple but fundamental propositions: mental illnesses do not exist; and coercions justified by them are wrong… my writings form no part of either psychiatry or antipsychiatry and belong to neither" (Szasz 2009, p. x).

One of the authors (RP), along with many others, has provided several extensive critiques of Dr. Szasz's views on mental illness, and these will not be belabored here (Pies 1979, Pies 2004). Moreover, there are plausible reasons to accept Szasz's claim that he is not "anti-psychiatry" in his motivation and intention—even if, as we believe, many of Szasz's claims have been used (or misused) to denigrate, marginalize and attack the profession of psychiatry. Other claims by Szasz have stirred useful debate and discussion; e.g., his staunch opposition to the use of mental institutions as holding facilities for sex offenders whose prison terms have expired ("Should states be allowed.." 1997).

In this regard, we wish to emphasize, as D.B. Double (2000) has argued, that not every person or viewpoint that is *critical* of psychiatry is necessarily *anti*psychiatry. For example, the Critical Psychiatry Network enunciates the following basic tenets:

> 1. "Modern-day psychiatry relies too much on the "medical model" and emphasizes diagnostic decisions. If psychiatrists adopted a more social or therapeutic community approach treatments would be more effective."

2. "The categorization of psychiatric illness is not as clear as most psychiatrists believe. Assessment of etiology too often fails to take personal and social factors into account."

3. "There is too much emphasis on the scientific possibilities of randomized controlled trials. The evidence of these trials is biased."

One might disagree with aspects of these claims, without necessarily regarding them as "anti-psychiatry."

Similarly, philosopher Thomas Schramme prefers to avoid the term "antipsychiatry" arguing that

> …it was coined [with] a polemic intention by adherents of the 'classical' psychiatry to suggest that the 'antipsychiatrists' would indeed like to abolish psychiatry and to leave the mentally ill to their fate. This is… wrong. Many critics of the concept of mental illness opted mainly for another kind of psychiatry, primarily focused not on the disease to be treated, but… [on the] human being with his particular mental problems… [therefore] whenever we refer generally to theories which reject the concept of mental illness… we will use the term "skeptical psychiatry" and "skeptics" in the case of the corresponding authors… (Schramme 2004, p. 94-95)

We agree with Schramme that "skepticism" regarding the theories and practices of institutional psychiatry accurately describes *some* authors, among whom Schramme would include Thomas Szasz, Michel Foucault, Ronald Laing, Ervin Goffman, Franco Basaglia, Thomas Scheff, and David Cooper, "…all of whom differ considerably in their reasoning…" but have in common the desire "…to challenge the traditional conceptualization of mental illness." (Schramme 2004, p. 95). Unfortunately, "skepticism", in our view, does *not* describe the more polemical and vitriolic attacks launched on the field of psychiatry from several quarters, often invoking the views of such "skeptics" to fuel their own, less reasoned philippics. Many of these overtly anti-psychiatry individuals are not academic philosophers and clinicians, but rather, "freelance" critics or self-described "survivors" of psychiatry who routinely post their views on the internet; see, e.g., "The Anti-Psychiatry Coalition" (Smith 2010). For these reasons—and consistent with the title of Schramme's own book chapter—we will retain the term "antipsychiatry" in this paper, while acknowledging that it embraces a wide diversity of viewpoints.

Foundational and Antifoundational Philosophies and Philosophers

Dichotomies of various types have long been imputed to Western culture and civilization. Thus, historian Thomas Greer suggests that "A longstanding division within Western culture… [has pitted] those who stressed science and reason, equality and democracy… [against] those who stressed tradition and sentiment, aristocracy and authority" (1987, p. 417).

Similarly, the philosopher and mathematician, Kurt Godel, dichotomized philosophy into the following catagories: "…skepticism, materialism, and positivism stand on one side; spiritualism, idealism, and theology on the other side." (Chalton 2008, p. 164)

While both these dichotomies have many points in their favor, we believe there is a more fundamental dichotomy that helps us understand some of psychiatry's most vociferous critics. In simplest terms, *foundational* philosophies and philosophers hold that we can *reliably describe a coherent, objectively-measurable "reality" or "truth,"* whether one considers the world as a whole, or specific aspects of it, such as the of disease. *Anti-foundational* philosophies and philosophers deny this claim, asserting that there are no objectively demonstrable "truths"—only various "perspectives" or "narratives" that cannot be privileged as uniquely or objectively "true." Anti-foundational views overlap with some elements of *post-modernism*, particularly those (such as Foucault's) that emphasize "power structures" and their effect on scientific and medical claims.

Foundational Philosophers

Although foundational thinkers may be "skeptical" in their epistemological claims, they ultimately evince a confidence—some might say, a faith—that the world and its constituents actually exist; that we may discern and describe the world more or less accurately; and that our knowledge of reality, if not certain, may at least be highly probable, if we conduct our investigations appropriately. By so doing, on this view, we can gradually build up a reliable and largely accurate picture of ourselves and the world. With certain caveats, a brief list of philosophers in this first group would include Saint Augustine of Hippo, René Descartes, Thomas Reid, and logical positivists like Bertrand Russell, Moritz Schlick, Rudolf Carnap, and A.J. Ayer. The early views of Ludwig Wittgenstein—ultimately, repudiated in his *Philosophical Investigations* (1953)—were also expressions of logical positivism.

A detailed discussion of each of these philosophers is obviously far beyond the scope of the present paper. However, we may imbibe something of the *spirit* of foundational philosophy by examining a few paradigmatic passages from some of the aforementioned thinkers. Saint Augustine provides us a convenient launching point.

As Gerard O'Daly observes, Augustine believed that skepticism is "…a form of despair of finding truth" and considered the refutation of skepticism "…to be of primary importance" (O'Daly 2001). Augustine asserts that the truth of propositions is such that "…no one can confuse them with any likeness to the false" (Augustine 1951). Indeed, Augustine produces an anti-skeptical argument that some have seen as a precursor of Descartes' famous "Cogito ergo sum." According to O'Daly,

> Augustine presents a version of the skeptical 'how do I know that I am not dreaming?' argument. Against the skeptics, he argues that some knowledge claims are not affected by the assumption that I am (now) dreaming. In fact, Augustine allows… against skeptical argument, that subjective states give certain knowledge about a 'world' that may simply be tantamount to whatever 'appears' to us" (O' Daly 2001, p. 163).

Furthermore—and more central to psychiatric nosology—Augustine believes that "…if our perception of an object is comprehensive, and our faculties are functioning normally, reliable information may be acquired about the external world" (O'Daly 2001, p. 164).

These, arguably, are claims consistent with the general western tradition of empiricism and empirical investigation.

René Descartes—who belongs much more to the tradition of *rationalism* than to empiricism—is widely associated with a radically skeptical approach to knowledge, taken in his *Meditations*. His famous "Cogito," after all, seems to have its origins in a radical exercise in doubt. And yet, in our view, Descartes is ultimately a *foundational* philosopher. Indeed,

"The *Meditations* opens by developing skeptical questions concerning the possibility of knowledge. Through a series of several carefully thought out meditations, the reader establishes (along with the author) the groundwork for the possibility of knowledge (scientia). *Descartes is not a skeptic, as some have insisted*, but uses skepticism as a vehicle to motivate his reader to 'discover' by way of philosophical investigation what constitutes this ground" (Smith 2007, italics added).

Foundational philosophies, of course, can include circumscribed forms of skepticism, as was the case with Descartes, and may even take the extreme form of *non-materialism* ("idealism"), seen in Bishop Berkeley's philosophy. Berkeley effectively dispensed with the concept of material substance, but most certainly was a *foundational* philosopher: he merely argued that the "foundation" of reality consisted of ideas in the mind of God! (Horner & Westacott 2000).

Perhaps the quintessential foundationalist was the founder of the so-called "Common Sense" school of philosophy, Thomas Reid (1710-96). Arguing against the influential views of Hume, Locke, and Berkeley, Reid took a resolutely commonsensical view of epistemology. Thus, Reid believed that "…we are directly aware of real objects and are, most of the time, roughly right about the nature of the objects of which we are aware… [and] that in having conceptions, we are aware of real objects that are roughly the way we conceive them to be" (Yaffe & Nichols 2009).

Logical positivism in its various forms is a modern-day expression of the foundational world-view. Associated with the so-called "Vienna Circle" led by Schlick and Carnap, logical positivism essentially held that *all knowledge is based on logical inference grounded in observable fact; and that only empirically verifiable statements are meaningful.* Some proponents of this philosophy prefer the term "logical empiricism," as explained by Oswald Hanfling:

> The philosophy of the [Vienna] Circle became known as 'logical positivism' or 'logical empiricism.' The former name is more usual, but the latter, preferred by Schlick, seems to me to be more appropriate. It has the advantage of indicating the affinity of the Circle's ideas with those of the empiricist tradition begun by Locke in the seventeenth century, and later represented by such thinkers as Mill and Russell. It is also readily connected with the Circle['s] interest in empirical science (Hanfling 1996, p. 195).

Although logical positivism or logical empiricism is nowadays viewed as largely discredited (Hanfling 1996), it continues to be influential in the philosophy of science, and—as we shall argue—in some antipsychiatry circles. As Hanfling puts it, "…even if the parent plant is dead, many of its seeds are alive and active in one form or another." (1996, p. 194).

Indeed, we shall see that many modern-day critiques of psychiatry (including that of Szasz) rely on a strongly positivist view of science in general, and of medical-psychiatric diagnosis in particular. At times, this positivist stance veers very close to *scientism;* i.e., "…the view that the scientific method is the only legitimate method for discovering truth and that science exhausts our knowledge of reality" (Horner & Westacott 2000, p. 242). Of course, one may reject this extreme view and still insist that psy-

chiatry is essentially a scientific enterprise. That does not mean, however, that psychiatry is *solely* or *exclusively* scientific; on the contrary, we would argue that there are dimensions of the clinical encounter that cannot be subsumed within traditional empirical science, and that this is true to some degree of *all* medical specialties.

Finally, a brief note on the views of novelist and philosopher, Ayn Rand, the founder of "objectivism": we might consider Rand's views—whatever their flaws—as perhaps the clearest expression of foundationalism. The Atlas Society—which "…affirms and embodies the core Objectivist values of reason, individualism, freedom, and achievement…" summarizes the foundational elements of Rand's philosophy as follows:

> "Objectivism" celebrates the power of man's mind, defending reason and science against every form of irrationalism. It provides an intellectual foundation for objective standards of truth and value ("Objectivism" 2011).

As we shall now see, this ringing manifesto of Western, rational-empirical objectivity is opposed in equally strong terms by several anti-foundational critics.

Anti-foundational philosophers

This tradition overlaps with that of skepticism, but unlike, say, the "resolved" skepticism of Descartes, modern anti-foundational philosophies do not move beyond a certain spirit of *negation*, or epistemological nihilism. As with foundational philosophers, the anti-foundational thinkers are not a homogeneous lot. Some have broad affinities with the Sophists and Skeptics of the classical era, such as Protagoras (ca. 490-420 BCE) and Sextus Empiricus (ca. 160-210 AD), respectively; as well as with some "nominalists" of the medieval period. Others, such as that late prototype of the anti-foundational philosopher, Friedrich Nietzsche (1844-1900), have affinities with thinkers in the Existentialist tradition. Closer to our own time, several philosophers of science, such as Thomas Kuhn (1922-96) and his contemporary, Paul Feyerabend (1924-94) are arguably anti-foundational in many of their claims. Finally, some of the claims of W.V.O. Quine (1908-2000) also seem anti-foundational, in that they appear to deny the possibility of certain types of "objective" knowledge. We shall say more about Quine presently.

Among those considered exemplars of the "post-modern" tradition, Michel Foucault (1926-84) and Jacques Derrida (1930-2004) also qualify as anti-foundational in many of their views. Foucault, of course, is famous for his critical history, *Madness and Civilization* (1973), which has done much to sustain antipsychiatric polemics, even as some critics of psychiatry (such as Szasz) have rejected many of Foucault's claims. Indeed, we shall suggest that Szasz approaches his critique of psychiatry much more from the tradition of *logical positivism* (empiricism) than from the anti-foundational, post-modern view of Foucault. Nonetheless, the peculiar relationship between Szasz and Foucault merits a brief digression at this point. As Daniel Berthold-Bond has succinctly put it,

> The differences between Szasz and Foucault are many and profound. This no doubt explains why the two, although contemporaries… never developed a dialogue… Notwithstanding these differences, the two share a number of basic claims in their critique of the idea of madness. By whatever different routes… both arrive at a view of madness as a social construction, and of the medical model of insanity as a moral and political mythology (Berthold-Bond 1995, p. 182).

To appreciate the spirit of the anti-foundational thinkers, we may begin with the Sophist, Protagoras (490-420 BCE), perhaps best known for his maxim, "Man is the measure of all things." As Cardinal has summarized Protagoras' epistemology,

> …because individual judgments are inherently subjective, we cannot hope to achieve objective knowledge. If human nature determines any judgment, then there is no universal truth on any subject… For example, while one person may find a room too hot, another may find it too cold.

> Since each judgment seems equally well justified, there cannot be an objective truth of the matter… (Cardinal 2008, p. 23).

In a leap of over two millennia, we find, in Friedrich Nietzsche (1844-1900) a spirit of anti-foundationalism akin to that of Protagoras. (Nietzsche also foreshadows some elements of post-modernism, which we shall address shortly). Nietzsche's particular variety of anti-foundationalism is usually referred to as "perspectivism"—what Robert Wicks has defined as "… the idea that there is no absolute, 'God's eye' standpoint from which one can survey everything that is" (Wicks 2008). To put it in Nietzsche's own terms, "The *only* seeing we have is seeing from a perspective; the *only* knowledge we have is knowledge from a perspective" (Nietzsche 1967). Similarly, as Robert Solomon notes, "Perspectivism in morals [for Nietzsche] means that there is no one scale of values and no single way of measuring people and their virtues…" However, Solomon adds that this does not mean that "…some perspectives cannot be seen as preferable to others…" (Solomon 1996, p. 203-204). Despite this qualification, Nietzche's perspectivism has probably fueled some post-modern critiques of psychiatry, as we shall see.

Willard van Orman Quine (1908-2000) is widely considered among the most influential American philosophers of the 20th century. Arguably, Quine is also the philosopher of language who most effectively undermined the claims of logical positivism—particularly the views of his former mentor, Rudolph Carnap. Thus, in his best-known work, *Word and Object* (1960), "…Quine self-consciously positions himself against empiricist attempts to construct reality solely from sense data… [however] it is perhaps not precisely with empiricism that he parts ways so much as with *foundationalist* empiricism" (Dipert 2003, p. 566).

There are at least two important senses in which Quine's work is anti-foundational; first, in its attack on the long-established distinction between *analytic* and *synthetic* statements (which has important implications for Szasz's recent claims); and second, in Quine's thesis that there can be no "objective" translation of texts. Specifically, in translating from one language to another, "…a correct translation cannot be discovered through any empirical means, free of all theoretical frameworks" (Dipert 2003, p. 569). We shall see that, in ways Quine probably never anticipated, these views have helped bolster certain anti-foundational, post-modern critiques of psychiatric diagnosis.

In some ways, the views of Paul Karl Feyerabend (1924-94) are even more "anti-foundational" than those of Quine. Indeed, the term Feyerabend himself applied to his theory was "epistemological anarchism"! Preston describes Feyerabend as "An imaginative maverick… [who] became a critic of philosophy of science itself, particularly of 'rationalist' attempts to lay down or discover rules of scientific method" (Preston 2009). More important for the purposes of psychiatry's anti-foundational critics, Feyerabend "…also sought further to downgrade the importance of empirical arguments by suggesting that aesthetic criteria, personal whims and social factors have a far more decisive role in the history of science than rationalist or empiricist historiography would indicate" (Preston 2009).

Indeed, for Feyerabend, not only was Western empirical science not "privileged" in any epistemological way, it gained its world-wide foothold through essentially *coercive* means—a notion some anti-psychiatry factions would later exploit in their attacks on institutional psychiatry. Thus, in his best-known work, *Against Method*, Feyerabend argues that "It is true that Western science now reigns supreme all over the globe; however, the reason was not insight in its 'inherent rationality,' but power play (the colonizing nations imposed their ways of living) and the need for weapons: Western science so far has created the most efficient weapons of death" (Feyerabend 1993, p. 3).

Preston (2009) suggests that several of Feyerabend's themes have affinities with those of post-modernism; and, indeed, Feyerabend's views provide a convenient launch point for our discussion of post-modernism.

Post-Modernism: Foucault and Derrida

It is probably fair to say that no fully satisfactory definition of "post-modernism" has yet been advanced, despite many learned treatises on "the post-modern." The difficulty lies in the pleomorphic and sometimes obscure nature of so-called post-modern literature, art, philosophy, and criticism. As Klages points out, a first-pass at the notion of post-modernism requires a brief sketch of what "modernism" entails. Klages links modernism—or at least, the modern era—with the European Enlightenment, which begins roughly in the middle of the eighteenth century (Klages 2003). Citing the work of Jane Flax, Klages notes (among other features) the following underlying ideas of the Enlightenment:

1. There is a stable, coherent, knowable self that is conscious and rational.
2. This self knows itself and the world through reason, which is the highest –and only "objective"—form of mental functioning.
3. The mode of knowing produced by the objective rational self is "science," which can provide universal truths about the world, regardless of the knower's perspective.
4. Such knowledge and truth produced by science will inevitably lead toward progress and improvement.
5. Language is rational, in that it represents the real/perceivable world which the rational mind observes.
6. Language embodies a firm and objective connection between the objects of perception and the words used to name them (between signifier and signified).

With these principles of Enlightenment-based "modernism" in hand, we can reach at least a notional understanding of post-modernism: in effect, it is *that view which denies, subverts, negates, or satirizes the"modernist," foundational principles of the Western rational-empirical tradition.* More specifically, following the terminology of the post-modern theorist, Francois Leotard, post-modernism denies the

legitimacy of "grand narratives." These narratives are essentially the enduring myths cultures and societies tell themselves, in order to sustain their own idealized self-image and coercive power. Post-modernism begins with "…the awareness that such narratives serve to mask the contradictions and instabilities that are inherent in any social organization or practice" (Klages 2003).

Science, in particular, comes to be associated with coercive power, in the post-modern world view. As Spiro (1996) observes, "…the subjectivity of the human subject precludes the possibility of science discovering objective truth. Second, since objectivity is an illusion, science according to the ideological argument, subverts oppressed groups, females, ethnics, [and] third-world peoples."

For purposes of this essay, two figures may be considered paradigmatic, in the history of post-modern thinkers: *Michel Foucault* and *Jacques Derrida.*

As one of the authors (RP) has argued elsewhere (Pies 2004), Foucault saw himself as an "archaeologist" whose task it was to uncover the latent structures of knowledge and power that are responsible for various Western cultural phenomena (Harland 1987). Foucault analyzed culture in terms of what he called "discourses." These are essentially the "…complex[es] of credentials, protocols, jargon, and specialized knowledge that defines theory and practice within the human sciences…" (Rohmann 1999, p. 142-43). On this view, it might be argued that the American Psychiatric Association's DSM-IV and DSM-V are prime examples of "discourses."

For Foucault, when such discourses coalesce around a dominant, socially-defining paradigm, the result is an *episteme* (from "epistemology"). Such epistemes are society's *vehicles of power*. Foucault argues that all disciplines—whether scientific, legal, political, or social—operate through a system of self-legitimizing texts and linguistic conventions. "Truth," therefore, cannot be absolute and claims of objectivity are impossible. In *Madness and Civilization* (Foucault 1973), as Rohmann (1999, p. 143) summarizes it:

> …Foucault maintained that the definition and treatment of 'insanity' constitutes a form of social control. Once 'madness' was defined as abnormal, rather than simply eccentric, its victims were separated from the 'sane' population by exile or incarceration; then, in the 19th century, physicians created a science of mental disease, parallel to physical medicine, with institutionalized procedures to restore patients to sanctioned standards of normalcy.

For Foucault, the *asylum*—ostensibly an attempt to humanize the treatment of the insane—was really a coercive attempt to confine and marginalize madness. It does not take much imagination to see how Foucault's arguments have been used to create a modern stalking-horse, behind which the opponents of psychiatry can stage their attacks; e.g., psychiatry is a "covert agent of the state", an "agent of social control", etc.

Jacques Derrida is probably best known for his theory of "deconstruction" and its application to literary texts. In a broader sense, however, Derrida is intimately associated with the anti-foundational beliefs underlying post-modernism. As Silverman has put it, "There is no doubt that with respect to the development of post-modernism and its relation to deconstruction, the role of Jacques Derrida has been of massive significance" (Silverman 2002, p. 110). Deconstruction per se is difficult to define, partly as a consequence of Derrida's own ambiguity on the matter. However, as a first approximation, the exposition provided by Prof. Mitchell Stephens (1994) is as good as any:

> To deconstruct a 'text'… means to pick it apart, *in search of ways in which it fails to make the points it seems to be trying to make…* Deconstruction, in other words, guards against the belief—a belief that has led to much violence—that the world is simple and *can be known with certainty. It confronts us with the limits of what it is possible for human thought to accomplish* (Stephens 1994, italics added).

Stephens also points clearly to the *anti-foundational* effect of Derrida's views, in an almost literal sense: "Hierarchies that had been taken for granted… get upended. These hierarchies are tripped up by the swarms of meanings that circle around the words used to support them" (Stephens, 1994). It does not take much imagination to see how highly hierarchical institutions, such as the profession of psychiatry, might also get "upended" by a critique that aims at showing how psychiatry "fails to make the points it seems to be trying to make." Indeed, in this "Derridean" sense, Szasz's readings of psychiatry's epistemological claims could be considered "deconstructive."

Foundational Critiques of Psychiatry

Undoubtedly the best-known foundational critique of psychiatric diagnosis has come from Dr. Thomas Szasz—though, as noted above, there are elements of Szasz's critique that overlap with anti-foundational arguments. The "foundation" upon which Szasz builds his case is that of pathology in general, and the neuropathological writings of Rudolf Virchow, in particular. More accurately, Szasz builds his case upon what he *believes* about Virchow's views and their implications—beliefs that have been challenged by several psychiatrists (Pies 1979; Pies 2004; Kendell 2004). Suffice it to say that the critique Szasz offers is *solidly grounded in the Western logico-empirical tradition*, if not in logical positivism as such. At least in his earlier work, Szasz argues essentially that (1) we know what constitutes genuine "disease"; i.e., the presence of objectively verifiable lesions or abnormal pathophysiology; (2) we know that so-called "diseases" like schizophrenia do not demonstrate any such objectively-verifiable abnormalities; and therefore, (3) we know that schizophrenia (and similar psychiatric inventions) cannot be genuine (ontologically "real") diseases.

Very recently, Szasz has presented a somewhat modified argument, grounded in the notion of

"analyticity"—the very target of W.V.O. Quine's critique. In the preface to the 50th anniversary edition of *The Myth of Mental Illness*, Szasz (1961) argues that:

> The claim that 'mental illnesses are diagnosable disorders of the brain' is not based on scientific research; it is a lie, an error, or a naive revival of the somatic premise of the long-discredited humoral theory of disease. My claim that mental illnesses are fictitious illnesses is also not based on scientific research; it rests on the materialist-scientific definition of illness as a pathological alteration of cells, tissues, and organs. If we accept this scientific definition of disease, then it follows that mental illness is a metaphor, and that asserting that view is stating an *analytic truth, not subject to empirical falsification.*

A full-blown critique of this argument is beyond the scope of this paper. However, it is instructive to note some of the key "properties" of Szasz's claim: (1) It is based on an implicit assertion that "analytic truths" are not empirically falsifiable—a claim that Quine is at pains to challenge; (2) It appears to remove from the realm of scientific investigation the question of whether schizophrenia or bipolar disorder, for example, are diseases or illnesses; (3) It conflates the terms "disease","illness", and "disorder" without any attempt to discern conceptual or clinical distinctions among them; and (4) It implies that there is a single, univocal "materialist-scientific definition of illness" to which one can appeal, and which then can be used unambiguously to compose an "analytic truth." Also note that the hyphenated term "materialist-scientific" implicitly suggests that science and "materialism"—roughly, the view that the only thing that exists is "matter"—are linked in some essential way.

Most curiously, Szasz's argument purports to rest upon an *analytic* statement—similar in kind to "All bachelors are unmarried males"—*while implicitly drawing upon the historical and empirical claims of "materialist" science.* Yet any putative "materialist-scientific definition of illness"—to the extent we can even specify one—did not arise *ex nihilo* or out of some syllogism; but rather, from specific *empirical observations* of cells, tissues and organs, by pathologists like Virchow and von Rokitansky. Thus, Szasz's argument that "mental illness is a metaphor" seems to us far from a straightforward "analytic" claim; rather, it appears to be a non-analytic claim that depends critically on a huge body of subsidiary historical, synthetic and empirical claims. Indeed, the statement, "Mental illness is a metaphor" does not in any way conform to the usual logical-semantic structure of true analytic statements, which are generally definitional tautologies; e.g., "All triangles contain three angles."

Furthermore, unlike Dr. Szasz, we very much doubt that there is any general or "essential" definition of physical or mental illness, or of "disease" in the abstract. Modern analytic philosophy—exemplified by the later views of Ludwig Wittgenstein—cautions us against precisely such essentialist claims. "Disease" may mean many things, depending on its intended use and context. Moreover, in our view, "mental illness" does not exist as a general entity or Platonic form, susceptible to examination for the quality of "metaphoricalness." What exists are *specific disturbances of affect, cognition, perception, reality testing, etc*, such as bipolar disorder—not "mental illness" in general. Indeed, what matters to clinicians in both general medicine and psychiatry is the recognition of *specific illnesses*, and how they affect particular individuals in concrete ways. In short, illness and disease are not metaphysical abstractions, but human realities, manifest as specific instantiations of suffering and incapacity in specific individuals. Finally, we would argue—contra Szasz—that a "materialist" view of disease is by no means the only one that may be called "scientific". For example, we see no logical reason why one could not construct a legitimately "scientific" view of disease based upon principles of *dysfunction, incapacity, phenomenology,* or *biological disadvantage*—not necessarily upon the "pathological alteration of cells, tissues, and organs" (Schwartz et al, 2005). As noted earlier, Szasz does not regard himself as being "anti-psychiatry", and has given a robust historical account of why this is so (Szasz, 2010). We have no reason to question Szasz's sincerity in his analysis of these matters. Nonetheless, Szasz's insistence that "mental illnesses are counterfeit diseases" (Szasz 2010) has found voice in the publications of many self-styled "anti-psychiatry" groups. Consider, for example, this passage written by Lawrence Stevens, JD, described as "…a lawyer whose practice has included representing psychiatric 'patients'" (Stevens 2003a): "In this pamphlet we will show that there are no biological abnormalities responsible for so-called mental illness, mental disease, or mental disorder, and that therefore *mental illness has no biological existence*…"

(Stevens goes on to offer a quasi-postmodern refutation of psychiatric diagnosis, as well, which we shall consider in the section on "Anti-foundational Critiques").

Stevens' foundational critique is built upon a scaffolding of selective quotes from a large cadre of mental health professionals, including Seymour S. Kety M.D., Steven Matthysse Ph.D., Jerrold S. Maxmen M.D., and Peter Breggin M.D., all in the service of showing that we *cannot identify any biological abnormalities* in any of the major psychiatric disorders; and that, *absent such physical "causes," these conditions cannot be considered bona fide diseases.* This is essentially a "Szaszian" argument, at least as Szasz presented it in his earlier works. In an update from 2001, Stevens (2003) provides the following quote from a psychologist, Bruce E. Levine Ph.D.: "Remember that no biochemical, neurological, or genetic markers have been found for attention deficit disorder, oppositional defiant disorder, depression, schizophrenia, anxiety, compulsive alcohol and drug abuse, overeating, gambling, or any other so-called mental illness, disease, or disorder" (Levine 2001, p. 277).

Both Stevens and Levine seem unaware that for most of the history of

medicine, only a handful of conditions identified as *diseases*—both by modern and ancient authorities—were understood in terms of their biological "causes." Nor did most conditions considered diseases by ancient and modern physicians have known biochemical or genetic "markers" associated with them. Indeed, to this day, we recognize many conditions as "diseases" (or disorders) without understanding much at all about their causes or underlying pathophysiology (Pies 1979; Pies 2004). To cite but one example, Amyotrophic Lateral Sclerosis (ALS), known as Lou Gehrig's Disease, has no known cause, and no specific laboratory, neuroimaging, or biochemical marker that reliably allows physicians to diagnose the condition *antemortem*. *Post*-mortem neuropathology is, of course, evident in ALS; but numerous post-mortem studies have also demonstrated fairly consistent neuropathology in the brains of those diagnosed with schizophrenia, including medication-naïve subjects (Fornito, Yucel et al. 2009). Indeed, while sensory and motor nerve conduction studies and electromyography (EMG) are a standard part of the evaluation, ALS remains essentially a *clinical* diagnosis, based primarily on the patient's history, signs and symptoms ("ALS and Neuromuscular Disorders" 2010). And, whereas a review of biomarkers in psychiatry is beyond the scope of this paper, it is inaccurate and deeply misleading to claim that there are "…no biochemical, neurological, or genetic markers" associated with "any" mental illness, disease, or disorder. On the contrary, several biomarkers, such as *abnormal smooth pursuit eye movements* and *enlarged cerebral ventricles*, have been repeatedly (though not invariably) associated with schizophrenia, notwithstanding the syndromal heterogeneity of this condition (Pies 2008a; Chua, Cheung et al. 2007). Incidentally, the oft-repeated charge that psychiatric disorders like schizophrenia and bipolar disorder "do not appear in pathology texts" is demonstrably false and has been so for many years (Pies 2008b).

It must be stressed, however, that even if *no* biomarkers existed for psychiatric conditions such as bipolar disorder and schizophrenia, they could *still* be considered diseases—or, more accurately, *instantiations of disease*—on the view that they entail *prolonged intrinsic suffering and marked incapacity,* in the absence of an obvious exogenous cause (Pies 1979; Pies, 2009). Indeed, in our view, the notion that *only* specific biological abnormalities can elevate a condition to the status of "disease" is a gross misapplication of a long-discredited logical positivism. More broadly, we concur with the late R.E. Kendell (2004) that "disease" is properly predicated of *persons* ("people")—not of minds, brains, bodies, tissues or organs.

Anti-Foundational Critiques of Psychiatry

Like post-modernism—a subtype of anti-foundationalism—anti-foundational critiques of psychiatry generally seek to deny, subvert, negate, or satirize the foundational principles of the Western rational-empirical tradition. Michel Foucault's analysis of psychiatry is perhaps the archetypal anti-foundational critique, and in many ways, serves as a kind of rhetorical template for many similar critiques of psychiatry.

As Richard Harland summarizes Foucault's view of psychiatry,

> …psychiatric medicine works only to the extent that patients are persuaded into speaking a scientific language about themselves. Patients are 'mad' because they have evaded the primary socialization which ordinarily enters into human beings along with their society's language; but they can still be subdued and at least partially socialized by a secondary web of restraining language… [This] seemingly successful result in no way proves the validity of the psychiatrist's language. The psychiatrist has not caught the truth of madness in his language, he has merely taught it to speak the same language back to him… this is a kind of objectivity that first creates its object for being objective about (Harland 1987, p. 104).

In effect, for Foucault, psychiatric medicine has merely fabricated a set of pseudo-objective technical terms and linguistic conventions—"delusions", "paranoid", "acute schizophrenia", etc.—and then imposed this framework on largely powerless social misfits. On Foucault's view, these unfortunates—labeled "insane" or "mentally ill" by psychiatrists—have been denied their own "discourse" and made to conform to the collective discourses (the *episteme)* of psychiatric medicine. Moreover, as Harland puts it, "…the mind that does not conform is treated as aberrational, as mad, as perverted" (Harland 1987, p. 108).

In many ways, Attorney Lawrence Stevens takes a similar tack in his critique of psychiatry. Stevens does not use the "post-modern" terminology of Foucault, but would almost certainly agree with the latter's general conclusions. For example, Stevens writes that,

> … the label schizophrenia, like the labels pornography or mental illness, indicates disapproval of that to which the label is applied and nothing more. Like 'mental illness' or pornography, 'schizophrenia' does not exist in the sense that cancer and heart disease exist but exists only in the sense that good and bad exist. As with all other so-called mental illnesses, a diagnosis of 'schizophrenia' is a reflection of the speaker's or 'diagnostician's' values or ideas about how a person 'should' be, often coupled with the false (or at least unproven) assumption that the disapproved thinking, emotions, or behavior results from a biological abnormality. Considering the many ways it has been used, it's clear 'schizophrenia' has no particular meaning other than 'we dislike it' (Stevens 2003b).

Each of Stevens' claims would require lengthy rebuttal. For our purposes, it will suffice to say that, like many critics of psychiatry, Stevens does not understand the role of "values" in the construction of so-called "medical" diseases, including but not limited to cancer and heart disease. As human beings who share certain goals in life, we understandably attach "value" to those conditions of the body that maintain and enhance life. Conversely, we tend to "devalue" conditions that limit life's possibilities,

decrease life's duration, or impede its highly-valued functions, such as walking, running, calculating, writing, etc. That is, *we construct a set of values as regards how a "healthy" human body "should be."* In a hypothetical society in which, say, *reduced exercise tolerance* and *dying at a relatively young age* were highly valued traits, a condition such as blocked coronary arteries would not be considered "disease"; on the contrary, it would be a highly-valued bodily state. Something resembling this "re-valuation" may be seen in present-day Hmong culture, according to author Anne Fadiman. In her book, *The Spirit Catches You and You Fall Down,* Fadiman describes the Hmong culture's view of epilepsy as follows:

> "...the Hmong consider *qaug dab peg* [epilepsy] to be an illness of some distinction... Hmong epileptics often become shamans. Their seizures are thought to be evidence that they have the power to perceive things other people cannot see, as well as facilitating their entry into trances, a pre-requisite for their journeys into the realm of the unseen..." (Fadiman 1998, p. 21).

For our purposes, the anthropological accuracy of Fadiman's claim is not critical. It suffices to note that, in principle, most conditions we regard as instantiations of somatic disease are ultimately grounded in very basic value judgments about how the body "should" function. From a logical and scientific perspective, such value judgments are no different than those relating to how the *mind* "should" function. In short, there is no fundamental *evaluative* difference between the claim, *"The coronary arteries should not be clogged with plaque, if you want good physical health,"* and the claim, *"The mind should not be bombarded with auditory hallucinations, if you want good mental health."* This is not to say that *body* and *mind* are similar constructs; that coronary artery disease and schizophrenia are related conditions; that the investigations required to establish their diagnosis are similar; or that the two conditions are experientially similar. It is simply to aver that whether or not we regard either condition—coronary artery disease or schizophrenia—as an instantiation of *disease* depends, in the final analysis, on certain kinds of *value judgments*.

Furthermore, "values" underlie Foucault's position that *his* particular episteme ought to be given greater weight than competing epistemes. Harland implicitly makes this point when he observes,

> ""Foucault... identifies with the victims. He identifies with them not because their discourse would be more true, but because it would be no less true, and yet *they are made to suffer for it.*" (Harland 1987, p. 108 italics added)

Indeed, while Foucault and Szasz proceed from quite different initial assumptions, both advance arguments against the activities of institutional psychiatry that are fundamentally *hortatory* and *value-based*—not scientific—in nature (Pies 2006).

Facts and Values in Psychiatry: Some Qualifications

An important caveat is needed at this point, even if it digresses from the main thesis of this paper. We do not want to suggest that the category called "disease" is *nothing but* a decision about values; or—as Lawrence Stevens asserts—that what is called "mental disorder" is *solely* a value judgment. The determination that someone suffers from disease in general or "psychiatric disease" (or "mental disorder") in particular is a complex and over-determined judgment, involving *facts and values*, objectivity and subjectivity. To quote from the *Oxford Textbook of Philosophy and Psychiatry,* chapter 20, "Values in Psychiatric Diagnosis":

> Our conclusion . . . [is] that the traditional medical model, and the claim to value-free diagnosis on which it rests, is unsupportable; and that, to the contrary, diagnosis, although properly grounded on facts, is also, and essentially, grounded on values. . . [This] is consistent with late twentieth century work in the philosophy of science. . . showing the extent to which the scientific process, from observation and classification to explanation and theory construction, does not depend on merely passively recording data, but is instead actively shaped in complex judgments. . .(Fulford et al. 2006, p. 565)

The *Oxford* authors wisely observe that "adding values" does not entail "subtracting facts" (Fulford et al. 2006). Thus, when we assert that someone with paraplegia has a *pathological* (from the Greek *pathos,* "suffering") condition, we are making a claim grounded in a certain kind of *value judgment;* namely, that the inability to move one's legs is in some sense "not a good thing." In a society that greatly valued paralysis and devalued walking, paraplegia would not constitute "pathology." On the other hand, we also "add facts" in asserting that Mr. Jones cannot move his legs *because he has suffered a fracture-dislocation of the lumbar vertebrae*. To the extent that this last conclusion is relatively free of cultural or personal values, and has some objective correlate in our radiograph of Jones's spine, our statement that "Jones has spinal disease" is more than *merely* a value judgment (though it surely *is* that). However, this fusion of "facts and values" is also true of psychiatric disease categories, such as schizophrenia, as has been argued elsewhere (Pies 2009). Furthermore, as Zachar and Kendler point out:

> Proponents of the evaluative approach [to understanding psychiatric diagnosis] would also point out that 'values' do not have to be inchoate, fuzzy, or undefinable. For example, in the DSM-IV-TR appendix, the Global Assessment of Relational Functioning Axis (V) can be seen as an attempt to operationalize psychiatric values. (Zachar and Kendler 2007)

Indeed, we should also be clear that not all critiques aimed at demonstrating the role of *cultural values* in psychiatric diagnosis are "anti-psychiatry"; nor do they necessarily originate from sources anyone would reasonably consider "anti-psychiatry" in his or her views. For example, Laurence J. Kirmayer MD, an academic psychiatrist, has argued that

> …many problems in other cultures (and perhaps in our own) that current nosology attempts to

> construct as discrete disorders are not deviant or disorders at all. They are culturally constituted and sanctioned idioms of distress—vocabularies and styles for explaining and expressing a wide range of personal and social problems. These idioms of distress cannot simply be added to our lists of discrete entities. Instead, they must be understood as rhetorical devices for making sense of human predicaments. (Kirmayer 1994, p. 7).

Jerome Wakefield presents a compelling critique of Kirmayer's argument (Wakefield 1994, p. 9-17); however, discussion of this rejoinder would take us far afield. Suffice to say that nothing in Kirmayer's view of cultural influences on diagnosis can reasonably be construed as "anti-psychiatry", even if—as Wakefield argues—Kirmayer's position seems to lay the groundwork for the sort of "concept relativism" that has been exploited by some in the anti-psychiatry movement. On the other hand, Kirmayer's rebuttal to Wakefield points out that even judgments based on supposedly objective "evolutionary" criteria are themselves dependent on certain value judgments; i.e., Wakefield's construct of evolutionarily-determined "natural function" is in fact dependent on a number of "culturally and historically relative" value judgments (Kirmayer 1994, p. 18).

"Hybrid" Critiques of Psychiatry

Though we have categorized antipsychiatry critiques as broadly divided into "foundational" and "antifoundational," it should not be surprising that "hybrid" arguments also abound. Some prominent critiques come from within the profession of psychiatry itself, as exemplified by the work of Peter Breggin, MD. Most striking in Breggin's various critiques of psychiatry is his appeal to published psychiatric research and leading scientific authorities, in support of the very claims he makes against the psychiatric profession. Breggin, who studied with Thomas Szasz, is the founder and International Director of the Center for the Study of Psychiatry and Psychology (ICSPP), described on its website as "…a network of people concerned with how mental health theories effect [*sic*] public policy, and all of us" (Breggin 2010). The views of ICSPP, of course, are not necessarily identical to those of Dr. Breggin; and indeed, the ICSPP website notes that whereas it is critical of "the so-called medical model of psychiatry," it is not opposed in all cases to the use of psychotropic medication "…by competent adults who have been thoroughly informed of their value, potential side effects and alternatives" (Breggin 2010).

A critical assessment of Breggin's numerous claims—most of which relate to alleged "toxic" effects of psychotropic medication and electroconvulsive therapy (ECT)—is beyond the scope of this article. However, a trenchant critique of Breggin's claims regarding Attention Deficit Hyperactivity Disorder (ADHD) is provided by psychiatrist Stephen Barrett MD (Barrett 2002).

Ironically, one of the fiercest critics of Dr. Breggin has been Jeffrey A. Schaler PhD—himself a prominent critic of the "medical model" of psychiatric diagnosis. Though beyond the scope of this review, the schism between Breggin and Schaler [detailed at great length on Dr. Schaler's website (Schaler 2006)], makes for interesting reading in the annals of anti-psychiatry and its many variants.

Conclusion

We have emphasized the structural and epistemological nature of arguments directed against psychiatric diagnosis and practice, often considered under the rubric, "anti-psychiatry." Though the various critics differ in their language and specific claims, all call into question the legitimacy and validity of present-day psychiatric diagnosis; and, derivatively, psychiatric treatment. We have argued that these schools of thought may be understood as arising principally from one of two main traditions, which we have called "foundational" and "antifoundational." Foundationalists derive their methods and claims from the Western logico-empirical tradition, and from logical positivism, in particular. In contrast, anti-foundationalists seek to undermine psychiatric diagnosis and treatment by subverting the very principles and "privileged narratives" that they claim underlie Western empirical science. Thomas Szasz has fostered a strong foundational critique of psychiatry, which has been "appropriated" in varying degrees by anti-psychiatry forces and factions. In contrast, Michel Foucault is probably the best exemplar of the anti-foundational argument against modern-day psychiatry.

Both foundational and anti-foundational arguments founder on several misapprehensions regarding the nature of "disease"; the role of "values" in determining the presence of pathology; and on supposed differences between psychiatry and the other specialties within general medicine. Many critics of psychiatry have persistently conflated epistemological and ontological claims regarding *the nature of "disease"* with hortatory arguments regarding *the legal and ethical treatment* of those diagnosed with serious psychiatric disorders. Such legal-ethical concerns are of great importance in their own right, but are logically distinct from ontological claims regarding the nature or treatment of psychiatric disease categories. Nonetheless, we would acknowledge many weaknesses and deficiencies in psychiatric nosology that warrant careful reassessment, as psychiatry faces the daunting task of creating the DSM-5 [see this journal, issues Vol. 17, # 1 & 2]. There are also many areas of psychiatric practice that must be examined from the standpoint of civil liberties and equitable, humane treatment of psychiatric patients. In order to defend itself—and, indeed, to *reform* itself—psychiatry must understand the nature of the arguments arrayed against it. We hope that the foundational/ antifoundational schema described here

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Does the Center Hold?: A Commentary on "Getting It from Both Sides: Foundational and Anti-Foundational Critiques of Psychiatry"

Jeffrey Bedrick, M.A., M.D.

Whether one thinks the "foundational/antifoundational schema…will provide a useful heuristic model" for understanding critiques of psychiatry, as the authors of "Getting It from Both Sides: Foundational and Anti-Foundational Critiques of Psychiatry" hope, will depend on whether one thinks such broad characterizations are useful, or whether one thinks the differences between the various thinkers that are said to be in each camp are as important as their similarities. I do not want to focus here, however, on whether such broad dichotomies are useful. Instead, I will focus on the defenses of psychiatry that the authors make in their response to what they see as the criticisms advanced by the two camps. If the dichotomy has provoked sound defenses of psychiatry, then perhaps it has already proved itself useful.

The defense presented of psychiatry against the "foundational critiques of Psychiatry" seems to rest on several main claims. The main claim is that those making the critique have embraced a view of science and medicine that is artificial and overly narrow. (I will leave aside, for the most part, the discussion of the new preface to *The Myth of Mental Illness* as I think it takes us away from the central argument about foundational critiques.) Thus, the authors write that "we very much doubt there is any 'essential' definition of physical or mental illness, or of 'disease' in the abstract." They argue that "what matters to clinicians in both general medicine and psychiatry is the recognition of *specific illnesses*, and how they affect particular individuals in concrete ways" (Italics in the original). Further, the recognition of these specific illnesses is not dependent on the known existence of specific "'pathological alteration of cells, tissues, and organs'" but may be based on concepts of "*dysfunction, incapacity, phenomenology, or biological disadvantage*" (Italics in original).

While a notion of psychiatric illness that is based on the concept of dysfunction is attractive, I am not sure that it would satisfy those in the foundational camp. One reason for this is that many foundationalists are what we may call strict foundationalists, who believe that higher order phenomena are founded on lower order phenomena and can be reduced to them. Thus the Vienna Circle believed in the unity of the sciences, and they had the dream of a unified encyclopedia of the sciences, which would show how sciences like biology rested upon and could be reduced to physics.

Further, even those foundationalists who are not reductionists might, I suspect, be unhappy with our authors' move here. For the authors go on to say that "to this day, we recognize many conditions as 'diseases' (or disorders) without understanding much at all about their causes or underlying pathophysiology," citing the case of amyotrophic lateral sclerosis. The particular case is in some ways both unfortunate and instructive. This past week a paper was published that claims to have found a pathology that underlies amyotrophic lateral sclerosis (Deng et al 2011). Pies, Thommi, and Ghaemi could certainly say that they could have picked any number of other examples, and the pathophysiology of the illness would still be unknown. This is true, but I think does not catch an important point. I think even before the recent paper, any neurologist would have been extremely uncomfortable if we had said to them that the underlying pathophysiology of ALS could never be discovered, or even further, that there was no underlying biological pathophysiology

to be discovered. Do we feel the same way about schizophrenia? About post-traumatic stress disorder? Borderline personality disorder? Fetishism? The authors write that "the notion that *only* specific biological abnormalities can elevate a condition to the status of 'disease' is a gross misapplication of a long-discredited logical positivism." I think there might be a difference between psychiatric disorders and other medical disorders here, however. The authors go on to say that "'disease' is properly predicated of *persons* ('people')—not of minds, brains, bodies, tissues or organs." I would imagine that those who study the diseases of plants might find this a strange claim. Those of us who are psychiatrists do not for the most part, I think, find it a strange claim—but I think that is because we are dealing with psychiatric diseases, *mental* disorders (if I can borrow some italics from our authors).

Let us now turn to the authors' response to the antifoundational critique. Here they say "whether or not we regard either condition—coronary artery disease or schizophrenia—as an instantiation of *disease* depends, in the final analysis, on certain kinds of *value judgments."* Again, I think many psychiatrists would not object to the notion that values enter in to our distinguishing between the normal and the pathological. The authors, rightly I believe, cite approvingly the authors of the *Oxford Textbook of Philosophy and Psychiatry* to the effect "that 'adding values' does not entail 'subtracting facts.'" But what are we to make of the claim that "In a society that greatly valued paralysis and devalued walking, paraplegia would not constitute 'pathology'?" It is a topic for another place, but I think there might be grounds in this latter case for saying that there was something pathological in the culture, just as I think the authors might take their argument with Foucault to him, on his own ground. Quoting Harland, the authors note that Foucault "'identifies with the victims. He identifies with them not because their discourse would be more true, but because it would be no less true, and yet *they are made to suffer for it*'" (Italics added by Pies, Thommi, and Ghaemi). But is our goal just to identify with the "victims" and their suffering, or to alleviate it? If the latter, then there are grounds for considering whether identifying with the "victim" or treating those with psychiatric disorders provides greater relief for their suffering. If we do this, I think we would discover that treatment (good treatment, of course, whatever that is) does more to alleviate suffering than does just identifying with the sufferer. To paraphrase Marx, the goal is not just to understand the suffering but to change it. This argument, I think, would potentially be a strong defense of psychiatry.

I think psychiatry can be defended against its critics. Doing so, however, I think entails acknowledging some differences between psychiatry and other branches of medicine. That there are such differences is not a weakness for psychiatry. It is rather a strength of psychiatry as a branch of medicine that does deal with persons, both in their physical and mental aspects. There is much in the paper to commend it, but I think it weakens its own arguments by the refusal to consider the differences between psychiatry and other branches of medicine, and not just their similarities. There is a reason why psychiatry and neurology are different branches of medicine. We do not need to be afraid of this difference.

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The Psychiatry Hoax

Michael A. Cerullo, M.D.

In their article, "Getting it from both sides: Foundational and anti-foundational critiques of psychiatry," Pies, Thommi, and Ghaemi do an excellent job of analyzing the arguments of the anti-psychiatry movement. While they focus on the writings of Michael Foucault and Thomas Szasz, one other writer of the period also needs to be included; R.D. Laing. During the 1960's, when anti-establishment rhetoric was at an all time high, these three writers laid the intellectual foundation for the antipsychiatry movement (Rissmiller and Rissmiller 2006). Pies and colleagues describe Szasz's arguments as foundational and Foucault's as anti-foundational. While this description is partly accurate it tends to obscure the more important fact that the arguments of Szasz and Foucault (as well as Laing) are very similar at a fundamental level. They all involve an extreme form of ontological skepticism: what lies at the heart of all their arguments is an outright denial of the *objective* existence of mental illness.

Foucault sought to explain away mental illness by questioning the motives of psychiatrists. He argued in *Madness and Civilization* that psychiatrists were sadomasochists conspiring to keep conventional bourgeois morality in place (Foucault 1965). Szasz (1960) claimed that mental illness could never be linked to dysfunction in the brain. Instead, he argued that the category of mental illness was an arbitrary judgment on the part of the psychiatrists who did not realize that mental illness was simply a disease of communication. Laing (1960) argued that mental illness may be an alterative and more authentic way of existing. Mainstream psychiatrists quickly provided effective rebuttals to the arguments at the time (Kelly and Feeney 2006), but what really mattered was that the public, and specifically the mental health reform movement, quickly lost interest in these extreme positions (Rissmiller and Rissmiller 2006). Psychiatric patients and their advocates began to demand the reform of rather than the disbanding of psychiatry. This was the beginning of the consumer movement and modern patient advocacy groups. These groups supported patient rights, deinstitutionalization, community mental health, and evidence based medicine (Dain 1994; Rissmiller and

Rissmiller 2006). They had little interest in naïve arguments denying the existence of psychiatry.

After the reform in nosology with the DSM-III and the explosion of research in biological psychiatry, the traditional antipsychiatry arguments finally became intellectual indefensible and whatever benign motivations that were once associated with them have long past. Mental illness is the number one cause of disability in the world (http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_part3.pdf)! What more do we need to debunk these extreme skeptical claims? In fact these arguments are so obsolete that labeling them "anti-psychiatry" gives them too much credit. Instead I would argue that they are better grouped with other conspiracy theories of the late 20th century. In honor of my favorite conspiracy theory, the moon hoax (the US faked the moon landings and they were filmed in the American southwest), I propose to label these radical ontological arguments the "psychiatry hoax". Given the overwhelming amount of evidence for the objective existence of mental illness the only way to deny this is to perpetuate a world wide conspiracy dedicated to generating the myth of mental illness.

Unlike the moon hoax, which doesn't seem to have that many serious negative consequences (other than perhaps encouraging more conspiracies), antipsychiatry encourages the persecution of a vulnerable minority of the world's population. History clearly shows that one dark aspect of human nature is to marginalize minority groups. The way to fight this is not use more rational arguments to debunk ridiculous claims, but instead to focus on decreasing the stigma of those with mental illness. Think of the difference in public reaction if Tom Cruise had ranted about the non-existence of cancer as opposed to mental illness. It is fair to say he would have received more than the mild rebuke he was given.

While the radical ontological skepticism of antipsychiatry has lost all respectability, a new generation of arguments has arisen to take its place. Those who espouse these arguments are more likely to quote Carl Elliot, Peter Kramer, and David Healy rather than Foucault, Laing, or Szasz. Here I will briefly review two of these neo-antipsychiatry arguments. Ironically, the first idea crystallized with the writings of a contemporary psychiatrist, Peter Kramer. Kramer (1993) was concerned that selective serotonin reuptake inhibitors might be altering personality and acting as general mood brighteners in those without depression. Kramer based his arguments on several patients he was treating in his private practice and published his musings in the book *Listening to Prozac* (Kramer 1993). While the arguments in Kramer's book have been shown to be incorrect (Cerullo 2006) the idea that modern psychopharmacology is serving as enhancement rather than treatment resonated with the many intellectuals and led to a new generation of skepticism towards psychiatry. The cosmetic psychopharmacology myth drifted into mainstream bioethics culminating with its acceptance by The President's Council on Bioethics (The Presidents Council on Bioethics 2003; Elliot and Chambers 2004). Prozac was seen as SOMA from *Brave New World* (SOMA was the mind dulling medicine given to keep the masses unaware of the horrible reality surrounding them). It was argued that psychiatrists were medicating the angst and difficulties of our stressful modern society away (The Presidents Council on Bioethics 2003; Elliot and Chambers 2004). This myth conveniently allowed for the acceptance of the reality of mental illness (and hence avoidance of any association with traditional antipsychiatry) but the denial of "mild" illnesses like depression, anxiety, and ADHD. While the traditional antipsychiatry at least didn't blame the victim, these newer arguments are not so kind. Depression is once again seen as a weakness and character issue and taking medicines is seen as a crux that simply masks the "real" issues.

A second class of neo-antipsychiatry arguments take the reasonable concern of biases in the psychopharmacology industry and concerns over conflict of interest and warps them into a radical skepticism. These arguments fit the post-modern (or anti-foundational) mold in that they play on the fact that nothing is ever completely certain. Overwhelming evidence is ignored in favor of trivial uncertainty. Post-modern arguments also tend to banalize opposing viewpoints and those who hold them. A good illustration of these arguments is the recent claim that many mental illnesses are the creation of "disease mongering." This derogatory label refers to the creation of disease categories purely for profit. If you follow many of these arguments closely they start with a reasonable concern about the excesses of industry and then finish by casting doubt on a large portion of psychiatry. Moynihan and colleague's illustrate this tactic in a series of articles (Moynihan et al. 2002; Moynihan et al. 2008). In their initial article published in a mainstream psychiatry journal they claim that "The social construction of illness is being replaced by the corporate construction of illness" (Moynihan et al. 2002). The authors then claim that:

> Within many disease categories, informal alliances have emerged, comprising drug company staff, doctors, and consumers. Ostensibly engaged in raising public awareness about underdiagnosed and undertreated problems, these alliances tend to promote a view of their particular condition as widespread, serious, and treatable … Alternative approaches — emphasizing the self limiting or relatively benign natural history of a problem, or the importance of personal coping strategies — are played down or ignored (Moynihan et al. 2002, p 886).

What is the evidence for these informal alliances? Five examples are discussed: baldness; irritable bowel syndrome; social phobia; osteoporosis; and erectile dysfunction. The evidence provided for the informal alliance to create social phobia centers on a marketing campaign in Australia. Roche was promoting moclobemide, one of its antidepressants, as a treatment for social phobia and they put

advertising money into an awareness campaign. The authors claim that Roche exaggerated the prevalence of social phobia in a press release. While this may be true, no referenced data is given by the authors to refute the numbers given by the company. Even if the prevalence of the illness was greatly exaggerated this would implicate only one arm of their conspiratorial trinity. There was no evidence given to support the involvement of psychiatrists or patient groups. Yet "disease mongering," as a post-modern argument, does not require it. Only the most minimal of evidence is required for the argument to count as an equally valid alternative. Once the reality of social phobia is doubted then the post-modern argument can freely generalize to other areas of psychiatry. In a subsequent article Moynihan et al. (2008) classified bipolar disorder as another creation of disease mongering. The only evidence provided was a reference to an article by Healy without discussion of its content.[1] Notice we have gone from an unsupported but believable claim that a drug company may have exaggerated the prevalence for a much understudied disorder to denying the existence of a disease which is the eighth leading cause of disability in the world (http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_part3.pdf).

Antipsychiatry is still alive and well in the twenty-first century. Traditional antipsychiatry arguments continue to flourish and have found a place among conspiracy theories which prosper even in the face of overwhelming contradictory evidence. As tragic as these theories are at least they were originally well meaning and helped to initiate the reform movement in psychiatry. Unfortunately the neo-antipsychiatry arguments supplanting them share more with the pre-enlightenment views of mental illness. Those with mental illness are not viewed as having a disease but instead are seen as the modern equivalent of being evil, i.e. having severe character flaws and moral weaknesses.

Endnote

1.In this article Healy (2006) wasn't technically arguing that bipolar disorder doesn't exist but instead that the prevalence of the disorder is being greatly exaggerated (again by the conspiratorial trinity). My favorite piece of evidence from the paper was Healy's accusation that the creation of the journal *Bipolar Disorders* supported his case for disease mongering. Thus as a researcher in the field of bipolar disorder and a reviewer and publisher in the journal *Bipolar Disorders* I should be classified as a disease mongerer.

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Taking Psychiatric Critique Seriously: A Role for Narrative Philosophy

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I very much appreciated Pies, Thommi, and Ghaemi's (PTG's) efforts to understand important and influential critics of psychiatry. The writings of Thomas Szasz, Erving Goffman, Michel Foucault, Franco Basaglia, Ronald D. Laing, David Cooper, Peter Breggin, and Bruce Levine do not often show up in psychiatric journals. This is a loss for psychiatry because some of these authors have had major influence in the humanities and social sciences (particularly Goffman, Foucault, and Laing) and others have had major impact in popular culture (such as Szasz, Breggin, and Levine). What makes PTG's article valuable is that they work to make sense of psychiatric critics within the psychiatric literature. By writing the article, they argue that it is worthwhile for psychiatry to understand its critics and to bring that understanding inside the knowledge base of psychiatry. The more psychiatry follows their lead, the more it will stay alive to the limits of psychiatric knowledge, aware of the many roads not taken, and appreciative of alternative points of view.

Staying open to alternatives is particularly important for psychiatrists because many of the people who disagree with us are also our patients or the loved ones of patients. Critics of psychiatry, in other words, do not stay in books, on the internet, or in activist

meetings. Like everyone else (including psychiatrists) they come to private offices, mental health clinics, and to emergency rooms in need of psychiatric assistance. When they do, they should meet psychiatrists who have *thought through in advance* some of the key reasons people are unhappy with psychiatry and why many believe psychiatry can be harmful. Otherwise psychiatrists are likely to more defensive and argumentative than helpful when working with critical clients and family members.

The first step in approaching different psychiatric worldviews is not so much philosophical as it is ethnographic. The first step is to understand psychiatric worldview differences are sub-cultural differences that are not unlike cross-cultural differences. As we have learned from cross-cultural medicine, lots of people in the world do not see things the way western healthcare workers do. Clinicians who lack awareness and skill in the face of cultural difference cause tremendous disruption for their clients and themselves. The example PTG reference, *When the Spirit Catches You*, dramatically portrays how not to act in cross cultural situations. The basic wisdom is the same in cross sub-cultural differences. Many critics of psychiatry come from different sub-cultural communities than psychiatrists. They may be from the same country and speak the same language, but when it comes to psychiatry they read different literature, listen to different podcasts, and go to different gatherings. The task of cross sub-cultural difference, like with cross-cultural difference, is to find common ground and to look for opportunities for diplomacy and negotiation. The thing not to do, as happened in *Spirit Catches You*, is get involved in an ethnocentric insistence of your sub-culture's world view. Instead, clinicians need to be adept at understanding different points of view and finding diplomatic alternatives—rather than going against differences head to head.

Philosophy's role arguably comes next because returning to basic philosophical assumptions can be a good way to find common ground. But, unfortunately, the way PTG turn to philosophy reinforces the differences between themselves and psychiatric critics. By structuring their history of philosophy and the world-views of psychiatric critics through a sharp foundationalist/antifoudationalist dichotomy, PTG create a classification system that divides more than it connects. That is not because classifying is bad thing in itself. Language users routinely make sense of the world using broad categories of people and things with common characteristics, and we may be able to salvage PTG's efforts. But classification can also become extremely divisive when it slides from helpful heuristic to a cultural *stereotype*. Before we can salvage PTG's efforts, we have to work through the way their article slides into problematic stereotyping.

Cultural theorist Stuart Hall articulates three toxic features of a classification system that has become a cultural stereotype: rigidity, splitting, and inequalities of power (Hall 1997). Stereotypes *rigidly* reduce people to simplified and exaggerated characteristics. Complexity is ignored and denied, and it is implied that everything that is necessary to know about the person can be known by referring to the traits of the stereotype. A stereotype declares 'this is what you are, and this is all you are.' In addition, stereotypes create *splitting* when those who do not fit society's norms are excluded, and their exclusion is fastened by fitting them to a set of characteristics deemed unacceptable – the 'Other'. This denies the possibility of any meaningful discourse about them or with them, and ensures their continued exclusion. Finally, this rigidity and splitting proves most effective when gross *inequalities of power* allow the dominant group to employ the strategy without challenge.

PTG's turn to philosophy ends up too close to the stereotyping Hall describes. The rigid dichotomy they use to organize the article loses complexity and makes it seem that the many philosophers and critics of psychiatry are *either* foundationalist *or* antifoundationalist. The impression the article leaves is that which category philosophers and critics fit is more or less all you need to know about them. PTG seem to say to psychiatrists that if you can recognize the core categories (foundationalism or antifoundationalism) you can ignore the many subtleties of the philosophers and the many complaints of the critics. You can go back to business as usual in psychiatry. No need to disturb your psychiatric slumber. PTG's classification also creates a stereotypical splitting that makes critics of psychiatry "Other" because critics, according to PTG, use discredited philosophies. PTG do not make it clear what their own philosophy is, but they do make it clear that they do not fall into either foundationalist or antifoudationalist traps. PTG have a philosophy that combines foundationalist facts with antifoundationlist values. The result is that that critics of psychiatry have a *bad philosophy*, while PTG have a *good philosophy* (albeit an unspecified one). And, finally, the power differential between mainstream psychiatry and its critics means that PTG's stereotypical classification of psychiatric critics risk not being challenged within psychiatric circles.

Uncannily, PTG's classification system creates the very thing that critics from a variety of philosophic backgrounds most complain about with regard to psychiatry's diagnostic practices. Critics of psychiatry's diagnostic manual complain that it too often becomes a stereotyping devise. By giving a diagnosis (and particularly by essentializing that diagnosis), clinicians split the normal from the pathological. The rigidity of this split means that there is not an option of complex and intertwining mixtures of "normal" and "pathological" experiences shifting from time to time. Nor is there an option of having understandable (not "pathological") reactions to a sick society. And certainly there is not an option that "pathological" symptoms are a gift that can motivate generative spiritual, political, or artistic consciousness and social movements. Critics argue that once you become a pathological patient you risk becoming "Other" to normal clinicians and normal society. Your voice is the voice of the mad. You are rigidly split off from the normal. To take you seriously would be ridiculous. And this dividing practice works across a power differential that too often sets up structures of oppression and subordination. We call this racism or sexism

in the case of racial or sexual stereotypes. We can call it sanism in the case of psychiatric stereotyping (Lewis 2006).

Still, despite the heavy handedness of PTG's philosophic turn, there is promise in their effort. The spade work they begin may be a useful starting point if we can loosen their categories a little. PTG are certainly right that although there are similarities critics of psychiatry are not all the same. Some critics come at it one way, some come at it other ways. On first pass, the two main examples PTG discuss, Szasz and Foucault, do seem to be roughly dividable along the lines PTG articulate. But PTG become too rigid when they use high-falluting philosophic categories of foundationalism/anti-foudationalism and try to essentialize these categories through a forced reading of Western Philosophy. PTG are closer to the right track when they historically connect Szasz with logical-empiricism and Foucault with postmodernism. Logical-empiricism and postmodernism are more flexible than foundationalism and antifoundationalism because they come closer to cultural/historical/contingent intellectual formations rather than essential timeless philosophical categories. To contextualize someone as a logical empiricists or a postmodernist is to talk about complex and often contradictory intellectual traditions which inform aspects of their work, not to classify them for all time.

But logical empiricism and postmodernism are also problematic because they are too dated for contemporary critics of psychiatry. It is important for psychiatrist to know that serious and deep critique of psychiatry did not stop with Szasz and Foucault. More and more scholars from humanities, social sciences, and the clinics are writing complicated and persuasive critiques of mainstream psychiatry (Angell 2011a, 2011b, Lewis 2009). For these new critics, neither foundationalism/antifoundationalism (terms which are way too blunt) nor logical empiricism/postmodernism (terms which no longer reflect today's intellectual styles) make a lot of sense. Yet, even though none of these categories work very well, there is still an echo of the distinction one can detect.

A less rigid way to get at the difference PTG are trying to make is to use a more simple and descriptive distinction between critics who rely heavily on science and those who do not. Using this distinction, particularly with regard to contemporary critics, we can see that some critics argue that psychiatry is *not scientific enough* and other critics argue that psychiatry is *too scientific*. Many mix the two concerns together, but we can heuristically describe two groups.

The first group of critics argues that there needs to be more science in psychiatry. There is not enough scientific funding to create an evidence base for psychiatry. The science we do have is not rigorous enough and is too often overly shaped by pharmaceutical interests. For these critics, what the field needs is a much more and much better science. The second group of critics comes from the other direction. These critics argue there is too much science in psychiatry. They complain that psychiatry seems to forget that humans (including scientists) have complicated mental lives and are located in dense cultural, historical, and political contexts. They argue that psychiatry's over idealization of science mystifies and naturalizes approaches to humans in favor powerful players (such as the pharmaceutical industry or consumer society).

The philosophic question for psychiatry is this: "Can the field live with the fact that it is vulnerable to these two serious critiques?" From one point of view, the science of psychiatry is insufficient and incomplete. We need much more science in psychiatry. From another point of view, the field is too dominated by science and neglects many other areas of human inquiry such as literature, philosophy, history, cultural studies, disability studies, the arts. We need to open psychiatry to areas of study beyond science. From my perspective, there are not necessary philosophic reasons psychiatry can not stay open to both of these critiques. Indeed, the clue that PTG give us to their philosophy—that psychiatry must be open to facts and values—seems to be a step in the right direction for coping with this double sided psychiatric critique. I have found that work in narrative theory can create a philosophy for psychiatry that provides a helpful way to do this (Lewis 2011). By standing on the shoulders of narrative medicine, narrative psychotherapy, and narrative philosophy, psychiatrists can recognize that there are many ways to tell the story of psychic pain and difference. All the stories people tell intertwine facts and values. Dominant stories rely on science centered models common in today's psychiatric subcultures, but other stories are critical of dominant models and prefer alternatives (such as psychoanalysis, existentialism, creativity, or spirituality just to name a few). Most use hybrid combinations of a variety of approaches.

All the models and hybrid combinations bring together facts and values. Narrative psychiatrists have a philosophy that allows them to embrace this diversity and multiplicity of options. As a result, when narrative psychiatrists meet people in the clinics who have had bad experiences with psychiatry or who are deeply critical of the field, they need not be defensive. If they are told, coming from one direction, that psychiatry is an immature science and that its categories are sloppy and destined to be the laughing stock of history, narrative psychiatrists need not react. They can simply say: "yes, the field does have its limits. We do not have the kinds of hard scientific data and consensus to work with that other areas of medicine seem to have. Many people in the field are concerned about this and are trying hard to develop psychiatric science along these lines." When they are told, coming from the other direction, that psychiatry relies to too heavily on science and has become the scientistic handmaid of the pharmaceutical industry and overconsumptive society, narrative psychiatrists need not rebut the claim. They can simply say: "yes, that is a real problem. Many people agree with this critique. They are trying to find solutions to powerful influences that shape the field and are trying to open the psychiatry beyond the sciences. In the mean time, let's see how we can be of help in your situation and make sure not to be overly attached to contemporary psychiatric worldviews."

Psychiatrists, in summary, would be wise to follow PTG's lead to take psychiatry's critics seriously. But, as we do this, our task is not to categorize our critics and dismiss them. Our task is to learn from alternative world views and subcultures, to recognize our many vulnerabilities, and to go humbly forward in the face of these vulnerabilities. One way to do this is to go back to the drawing board and rethink our basic philosophic assumptions. When we do that, we see that we are in a field (like other fields) where facts and values get all mixed up. That means we need to be smart about both facts and values and about the different ways that facts and values can be combined for living with and through psychic difference. Narrative psychiatry is a particularly helpful way to do this and a valuable philosophical scaffold for organizing our research, education, and practice with this kind of subtlety.

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On Being 'Entitled', or Why a Little Knowledge Is a Scary Thing

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As a former, though admittedly minimally paid, philologist I find my own neural wiring unwittingly, often annoyingly, attuned to 'the little things' when I read a newspaper, a book, an article. Anomalies that interrupt the 'flow', things like grammatical errors, spelling errors, punctuation errors, leap out at me like pathology to an experienced radiologist. Or, perhaps, this linguistic hyperawareness has more to do with my strict twelve years of primary Catholic grammar schooling. Whatever the etiology, split infinitives, dangling participles, enclitic relative clauses all set off tiny 'neuro-shocks' in my language-addled brain. And so in this paper by Dr. Pies, Ms. Thommi, and Dr. Ghaemi, where early on there is a parenthetical reference to "the section *entitled* 'Foundational Critiques of Psychiatry'". At first I was sure this was simply an oversight, that the editors meant to correct this to read "the section *titled*..." After all, it is difficult to imagine something as inanimate and inert as a 'section' to be worthy of 'entitlement'. But as I thought about it, I more and more came to appreciate, whether intended or not, the *double entendre* of the phrase on the paper; that is, that somehow that section of the paper, on 'Foundational Critiques', was either to be considered as having been afforded pre-eminence among theories, or as nothing more than a lexical mistake. This interpretation grew even more appealing given that only two examples of foundational anti-psychiatry arguments are presented: Thomas Szasz, who, perhaps wisely, has eschewed the term 'anti-psychiatry' as co-opted by a spectacularly narcissistic 'blogosphere' he could not possibly have seen coming, and the latter-day Renfield to Dr. Szasz' Dracula, attorney, blogger, and psychiatric ambulance chaser, Lawrence Stevens. And more, the fact that Mr. Stevens is included in the same conversation with St. Augustine, Descartes, even Thomas Reid, makes the whole endeavor, in the bewildered words, previously quoted, of young, if perhaps somewhat psychotic, Alice, 'curiouser and curiouser'. (Of course I run the risk now of the editors correcting this oversight in the meantime, and rendering my little rant here irrelevant. Che sará.) It should also be noted – *emphatically* noted – that the largest and most influential anti-psychiatry standard-bearer, the insurance industry, is wholly ignored in this piece. For it is surely no coincidence that the rise of anti-psychiatry parallels the explosive invasion of the private insurance lobby.

I will address Stevens briefly later in this commentary, but for now Szasz then is really the only 'Foundational' example of anti-psychiatry presented. The authors do take pains to attack Szasz' arguments as distilled down to his assertion of 'analytic truth' determining the existence of illness. More broadly, Szasz' whole argument is one of negation, one might even say denial. Mental illness plainly and simply does not exist. Evidence is not produced *against* the existence of mental illness. Rather, *lack* of, literally, microscopic evidence in support of the existence of mental illness is the crux of the argument. This lack of evidence is defined as mental illness' distinct lack of "pathological alteration of cells, tissues, and organs". Utterly ignoring the forest for the trees, Szasz then wraps up this assertion with the at worst, contradictory, and at best, bizarre, claim that "mental illness is a metaphor...an analytic truth, not subject to empirical falsification". Again, the philologist in me is drawn to the striking use of the term 'metaphor'. A metaphor, of course, is a comparison between two things, or in Aristotelian terms, "the application of a word that belongs to another thing". ([1], p. 1457b) Szasz, by virtue of his defining mental illness in terms of its negation, implies that since mental illness is not a pathological phenomenon, then it must be 'something else'. In good old-fashioned postmodern terms, it must be an 'Other'. This interpretation is the only way I see to resolve Szasz' strangely literary claim with his otherwise odd appeal to "empirical falsification". In other words, the 'Other' that is mental illness can only be conceived of as an 'analytic truth', and this plants Szasz firmly among the supposed 'Anti-Foundationalists', not the 'Foundationalists'. This then reduces the 'meta'-categories of anti-psychiatry proponents to one.

Attorney Lawrence Stevens thus finds himself, by virtue of his self-promotional blogging, abandoned as the only 'philosopher' of 'Foundational' anti-psychiatry. That is, he and a laundry list of disillusioned

psychiatrists and psychologists who continue to regurgitate the 'microscopic argument' ad nauseam. There is no new argument at all among them. They randomly regurgitate Szasz in the name of self-interest, for at no other time in history has there been doubt as to the existence of mental illness. As is the case with any number of diseases across medical boundaries, there do not yet exist biological markers of mental illness. Therefore, mental illness does not exist. I can discern no value in Stevens' cataloguing of such statements. One may as well appeal to every experiment that fails to yield any pathological needles in the genetic haystack of any number of diseases. More prevalent than the authors' example of ALS, Alzheimer's disease – and frankly a fair percentage of neurologic disorders – by this logic, do not exist. In other words, there is no serious thoughtful 'Foundational Critique of Psychiatry'. (There are certainly profitable foundational critiques, and this would likely go a long way in explaining the bull-headed, unimaginative reiteration of the obvious.) The current authors present evidence enough against such one-dimensional claims. And in so doing, they have essentially rendered insignificant their one presented case of a 'Foundational Critique of Psychiatry'.

There really is no double-barreled assault on psychiatry. This is not to claim that anti-psychiatry does not exist. Rather, the proponents are of the single barrel variety, and firmly entrenched in constructivism alone. The authors do provide brief historical outline of thinkers they classify broadly as either 'Foundationalist' or 'Anti-Foundationalist', but none of this typological scheme is presented as bearing on the question of psychiatry or mental illness in any way. Assuming a dialogue is implied, to return to the proffered examples of Augustine and Descartes, that these thinkers would start with a premise that questioned the very existence of the material world and themselves, I would contend, is very much akin to 'Madness' (to borrow a favorite synonym of the relativists). To question one's very existence, after all, is to deny the evidence of one's own perceptions. I see, I hear, I touch, I taste, I smell, all recede in the presence of Descartes' sixth sense, 'I think'. To be fair, Descartes does consider the prospect that, by denying his own existence, he too might be 'mad'. But he quickly dismisses this contention in the context of his ability to entertain the proposition at all, or, in his ability to use his 'Cogito'. In Cartesian terms therefore, madness is not compatible with reason at all. The underlying assumption here, of course, is that the 'madman' then lacks the ability to think, to reason. In other words, the madman's distrust of his senses is somehow pathological. Both Foucault and Derrida famously took issue with these conclusions, this in their efforts to conclude that the madman indeed does not lack a Cogito. Rather, according to Derrida, he lacks the ability "to reflect it and retain it". ([2], p. 58) The discovery thereby – or perhaps more appropriately, the initial best expression of – the Ratio, of reason, from its inception necessarily implicated its 'Other'. From the moment existence was confirmed as a subjective self-identity, so the possibility of the loss of self-identity emerged, i.e. reason's Other, madness. This certainly did not establish madness as a distinct, verifiable entity per se. Rather, in good constructivist fashion, it merely marked the initiation of discourse on the subject.

This is overlooked in the overall lack of historical context in this article by Dr. Pies et al. Anti-psychiatry has become an all-encompassing term only over the last forty to fifty years, coinciding with the development of antihumanism. Madness, however, or reference to such a pathology in the medical literature dates back at least to the Babylonian and Egyptian eras. (3) In broader historical terms, Foucault's premise that madness is a social construct requiring the segregation of the mad as a logical consequence of increasing egalitarianism is difficult to maintain. Though historically unproven that the mad were otherwise 'contained' before the seventeenth century, it is equally unproven that the mad were assimilated in any functional way into day-to-day life. In fact there are Babylonian records hinting at the medically prescribed killing of the mad. ([4], pp. 14-15) Here I find myself more in agreement with Gauchet and Swain's thesis that before the (late) Western assertion that all men are equal what allowed for any supposed toleration of the madman at all was in fact his 'Otherness'. The madman, in this view, was somehow different from other men. And in societies that recognized, and accommodated, certain people as slaves, or subhumans, and others as gods, or superhumans, the madman might fall anywhere in between. As certain societies, typically in the West, became more egalitarian, so Gauchet and Swain claim, what causes problems for the relativists is that the madman then lost his 'Otherness'. He could no longer, in good egalitarian – or, in up-to-date parlance, politically correct – terms, be thought of as an 'Other'. By law now he had to be thought of as the 'same'. Thus the madman was not necessarily assimilated, but accommodated. Swain himself never disputes that madness is the 'Other' of reason, "but it is an other that is somehow inside of it, and whose unexpected arrival is contained in the very logic of its development". ([5], p. 94) Madness is not an opposite of reason, but an 'Other'. In democratized society then, madness and reason must coexist. The development of moral treatment in this regard was essentially the forced belief that there was in fact present a Pathology (madness) as opposed to Healthy (reason). The door thus stood wide open for the psychoanalyst.

Of course the anti-Oedipus crowd has praised the madman in various incarnations as the last rebel, the staunchest of resistance fighters, less against democratization per se than against rampant capitalism. ([6], pp. 1-50) In this context the postmodern pendulum has swung the other way, and ideology is inextricably woven into the fabric of the 'Other', of madness. As a sociopolitical martyr, he-who-is-mad then flies in the face of Hegel's concept that notions are the result of themselves. The madman is no more motivated to fight for a principle than he is motivated at all. Left to a world of madmen, there would be no notions. Psychopathology, though a necessary condition

for the anti-Oedipeans, is greatly diminished thereby, and here is where, despite his optimistic stance, I must take issue with Dr. Schramme's belief that anti-psychiatry is a misnomer. It is my understanding, from my reading of their discussions and interpretations, that the anti-psychiatry crowd in fact advocate nothing less than the abandonment of the mentally ill to their own devices. Indeed I often wonder if any of the steadfastly anti-psychiatry crowd, Dr. Szasz included, has ever been face-to-face with a floridly psychotic or manic individual, with an acutely suicidal or homicidal individual, with a catatonic individual. To return once more to the issue of historical context, it should be remembered how easy it is to forget just how horrific, how terrifying, was the course of untreated 'madness', the type of madness that faced medical professionals prior to the advent of anti-psychiatry. (Indeed, a disease so horrific as to have medical professionals prescribe, at times, death as the only recourse.) Certainly one can easily praise the 'rebelliousness' of these 'free thinkers' from an intellectual distance. But the simple fact is that there is no conscious rebellion there. The schizophrenic no more chooses to rebel against society than the paraplegic chooses not to walk.

Even more plainly and simply I suppose the best way to disprove any 'Foundational' attacks on psychiatry would be to gather the adherents in a room, then present to them a floridly impaired individual, very much like I would imagine presenting a captured Bigfoot to a gathering of skeptics. I'm sure there would be those steadfast few willing to deny the evidence before their eyes, to deny their own sense perception, but at that point the objection could no longer lie on Foundational grounds. True, the 'Anti-Foundationalists' would more likely be among those disputing the evidence before their eyes, but this claim would present an interesting contradiction to relativist thought in general: that is, creating a social construct around evidence presented to everyone, at the same time, despite any one individual's cultural context.

Lastly, I would like to re-assert Slavoj Žižek's point regarding how properly to judge thought in an historical context. Žižek rails against arrogantly judging the past with twenty/twenty hindsight. Rather, he states "when we are dealing with a truly great philosopher the real question to be raised concerns not what this philosopher may still tell us…but rather the opposite…how our epoch would appear to *his* thought". ([7], p. 6, author's italics) The current authors do indeed provide two cursory histories of what they respectively call 'Foundational' and 'Anti-Foundational' thought. But they fail to engage in any meaningful dialectic between the past and the now. In fact, they fall into the historical trap both of creating new terms, and even more egregiously, propagating the new terms of others, i.e. 'Foundational', 'Anti-Foundational', 'Scientism', 'Skeptical Psychiatry'. Generating novelty terms, again thinking as a philologist, only removes one further from any meaningful dialogue with the past. (I think of this less as an infinite regress, than an infinite progress: modernism begets postmodernism, which begets post-postmodernism, et cetera, ad infinitum, ad nauseam.) The question perhaps the authors should be asking is not whether critics of psychiatry have foundational or anti-foundational bases – terms both so 'meta', by the way, as to encompass the whole of intellectual history – but whether psychiatry itself remains relevant when viewed through the eyes of "the truly great philosopher".

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Reform or Revolution: Response to Pies, Thommi, and Ghaemi's "Getting It From Both Sides: Foundational and Antifoundational Critiques of Psychiatry"

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The authors of "Getting It from Both Sides" maintain that, "in order to defend itself—and, indeed, to *reform* itself—psychiatry must understand the nature of the arguments arrayed against it" [authors' ital.]. Manifestly, then, the authors believe that psychiatry is in need of reform. However, the authors see psychiatry as very much embattled, threatened by the barbarians at the gate (my metaphor). Interestingly, then, the entire body of their paper is given over to presenting and critiquing the "anti-psychiatry" movement, "the arguments arrayed against" psychiatry, which the authors categorize under the rubrics of "foundationalist" and "anti-foundationalist" (loosely equated, respectively, with logical positivism and postmodernism). It seems, then, that their advocacy of reform is related to the authors wish to stave off revolution. (The authors do not use the term 'revolution' in their paper. Nevertheless, as I will attempt to show, I believe

it is indeed what they are arguing against.)

The authors find all of the positions under the rubrics of foundationalism and anti-foundationalism, (including those in a lengthy philosophical excursus), to be deeply flawed. What, then, we may ask, is the relation between, on one hand, their belief that reform is needed, and, on the other hand, their intensive, albeit "heuristic," critique of the arguments of the anti-psychiatry thinkers? (The authors accept the term "anti-psychiatry" to designate the leaders of the "assault" (a term they do use) on psychiatry, though they differentiate it from the earlier, Laing inspired version.) Clearly, the authors do not aim to pose a fundamental challenge to the psychiatric establishment that uses DSM (and will use the forthcoming DSM-5) as its nosological bible; rather, they aim to debunk any view they determine advocates for, not *reform*, but rather the view that psychiatry is in need of a *radical, or even revolutionary transformation* (again, these terms are not used by the authors). Such a transformation would probably entail, one way or another, a radical transformation of psychiatric nosology possibly leading to rejection of the DSM approach to nosology *tout court*. Certainly, this would be true of two of the anti-psychiatry critics the authors focus on: the foundationalist Szasz, since Szasz denies the existence of mental disease; and, the anti-foundationalist Foucault, since he viewed mental illness as an instrument of oppression by the ruling classes. (I am here just explicating the authors' views of these critics.)

That the authors reject radical transformation of psychiatric nosology and seek to neutralize such tendencies is evident in their description of the types of reform they endorse. They signal their acceptance of the DSM when they write that, "Nonetheless, we would acknowledge many weaknesses and deficiencies in psychiatric nosology that warrant careful re-assessment, as psychiatry faces the daunting task of creating the DSM-5…" They go on to provide their own list of improvements needed, and this list is itself manifestly one that reflects the classical aims of liberalism: "There are also many areas of psychiatric practice that must be examined from the standpoint of civil liberties and equitable, humane treatment of psychiatric patients." In the previous paragraph they had pointed out the importance of concerns such as "*the legal and ethical treatment* of those diagnosed with serious psychiatric disorders." In contrast, from a radical, as contrasted with a reformist, standpoint, one would ask, rather: How is it that abuse of psychiatric patients, including racism and sexism, has been endemic to psychiatry and the treatment of people with mental disorders from the beginning and how is it that the problem remains intractable? In this regard, we can ask, also: Is it possible that failure to eliminate psychiatric abuse of patients is related to the way certain perspectives in psychiatry, e.g., the medical model, (which the authors critique for its pretensions to value neutrality) facilitate, or fail to raise consciousness regarding, dehumanization of patients? How then do the authors construe what I have referred to as a radical critique of psychiatry and the DSM, the sort of critique that, as we shall see, they clearly reject and from which they apparently seek to shield psychiatry?

In their conclusion, the authors register the nub of their critique of the philosophical/psychiatric foundationalist and anti-foundationalist critiques of psychiatry that they discuss in their paper:

> Many critics of psychiatry have persistently conflated epistemological and ontological claims regarding *the nature of "disease "* with hortatory arguments regarding the *legal and ethical treatment* of those diagnosed with serious psychiatric disorders. Such legal-ethical concerns are of great importance in their own right, but are logically distinct from ontological claims regarding the nature or treatment of psychiatric disease categories.

It is, I will show, these " epistemological and ontological claims" or potential claims that the authors see as revolutionary (my term) in their implications and for this reason wish to dissociate them from critical claims that they, the authors, deem to be within the scope of their own, liberal (my term), critique of psychiatry. Let us see how this plays out in their discussions of such epistemological and ontological claims. In what follows, I will point out that the authors, while themselves pointing to the epistemological and ontological stances of some critics of psychiatry, nevertheless elide any discussion of these as such, nor do they indicate that their own stance implicitly posits an epistemology and ontology. Moreover, while they claim, and I agree, that a scientific view of psychiatry does not require a materialist ontology or an epistemology that is grounded in a materialist ontology, on the other hand, they do not provide any other rationale or grounding for the scientificity of their approach.

The primary representative of foundationalist claims against psychiatry that the authors focus on is Thomas Szasz. They reduce Szasz's perspective, not unreasonably, to four principle tenets, one of which has direct bearing on ontology. Szasz's stance, they maintain, "implies that there is a single, univocal 'materialist-scientific definition of illness' [quoting Szasz] to which one can appeal, and which then can be used unambiguously to compose an 'analytic' truth." Indeed, Szasz is unambiguous regarding his commitment to scientific materialism and to an alleged "scientific-materialist definition of illness as a 'pathological alteration of cells, tissues, and organs'" (authors quoting Szasz). Scientific materialism is indeed an ontological standpoint that avers, as the authors point out in their philosophical excursus, that "matter is the only thing that exists." The authors go on to argue against Szasz's views on many fronts, and much of what they write is sound. All of this notwithstanding, to refute an ontological stance one must not merely point it out; rather, one must address it directly and pose an alternative ontology, or a rationale for abjuring to posit an ontology. It is all well and good to say that Szasz and others conflate ontology and epistemology with legal and ethical issues; it is

quite another task to show that an ontology like scientific materialism is not philosophically adequate in general, and in particular, not adequate to provide a philosophical foundation for psychiatry. Moreover, quite a few philosophers, Plato and Levinas, for example, would challenge the authors' claim that ontological and epistemological issues are logically separable from ethical and legal issues. Separability for the sake of discussion, or, to use one of the authors terms, for "heuristic" purposes, does not necessarily imply philosophical or logical separability.

If scientific materialism were to be universally adopted as the one true philosophical, ontological foundation for psychiatry, and, *mutatis mutandis*, for all other disciplines, (a situation that I for one, a devotee of Husserlian phenomenology, would strongly oppose, to say the least!), this would indeed have revolutionary implications. That is, it would have revolutionary implications *if it were acknowledged as such.* It would mean, for example, that all mental phenomena of either health or disorder would be held to be exclusively phenomena of materiality, thus rendering irrelevant all approaches to psychiatric nosology and treatment of adverse mental conditions whose theorists and practitioners deny the validity of materialism vis-a-vis reality and in their theory and practice. Scientific materialism, systematically construed, would rule out any other ontology. Let us see how the authors dodge this problem.

They write:

> Finally, we would argue—contra Szasz—that a "materialist" view of disease is by no means the only one that may be called "scientific." For example, we see no logical reason why one could not construct a legitimately "scientific" view of disease based upon principles of *dysfunction, incapacity, phenomenology, or biological disadvantage*—not necessarily upon the "pathological alteration of cells, tissues, and organs….

In what sense does this statement even suggest a rationale for the non-materialist scientificity of the approach it announces? The authors speak of "principles" of dysfunction, etc. What is the nature of these principles drawn from, I assume, empirically observed regularities? What is their ontological status? The authors might argue that they are not obliged to discuss or provide an answer to these questions here because their evidence is empirical and can be observed repeatedly and systematically. But, their view in no way rules out a materialist ontology. For example, the "principles," or the observed regularities from which they are inductively drawn can be construed as indicative of neural pathways and thus as materially constituted. Why should we not so construe them or attempt to show this as some neuroscientists do? My point is not to promote a materialist ontology—indeed, as just noted, it is not at all the ontology that I favor! I only aver that if one rejects such an ontology then one is obliged to explain the basis for that rejection and provide an alternate view. Why is scientific materialism philosophically unsound? The authors say nothing. Nor do they provide a rationale for non-materialist scientificity. More specifically, the authors are explicating a concept of mental illness that accepts a notion of 'disease' broadly construed, but rejects scientific materialism. What then is the ontology of disease that they wish to substitute for scientific materialism, one that will enable both scientificity and "reform" of DSM?

The authors next take on what they deem, quite correctly, to be anti-foundationalist critiques of psychiatry. The authors do not at all discuss ontological aspects of the two critiques of psychiatry they focus on, those of Foucault and Anthony Lawrence Stevens, who (Stevens) has posted articles on the antipsychiatry.org website and who is associated with the Antipsychiatry Coalition. However, in their philosophical excursus they do make clear that the anti-foundationalists reject all "absolutes." These thinkers project a profound epistemological skepticism regarding truth; however, their views on ontology are exceedingly unclear. Nevertheless, their work should be subject to critique on this point because they themselves never address the question of their own ontology. The authors' central critique of both Foucault and Stevens is that these writers maintain that psychiatry is a method of oppression of those deemed by its adherents to be misfits, to be people who fail to conform to societal expectations. In their discussion of Foucault, Derrida, and postmodern thought, their point is that the postmodern standpoint, that of Foucault in particular, is judgmental and ipso facto unscientific. The sense of the author's critique of anti-foundationalist attacks on psychiatry is that their stance is both unscientific and is an attack on the very possibility of science, and on the very existence of 'reason.' They reject psychiatry on political and ideological grounds. From this point of view, one might argue that the postmodern anti-foundationalist would indeed like to see a revolution—the complete abandonment of psychiatry. One might say (tongue in cheek) that Szasz's scientific materialism or scientism suggests revolution from the 'right,' while Foucault et al represent revolution from the 'left'!

As the authors clearly show, postmodernism is a form of skepticism that rejects any claim, not just to possess truth, but even to be seeking it since these thinkers maintain (contrary to the phenomenological standpoint) that any notion of a truth as such or in-itself is ipso facto foundationalist and has the potential to lead to totalitarianism and authoritarianism. However, the authors do not bring to bear on their discussion a question that is relevant to their perspective, and which, in my view, strikes at the heart of postmodern thought: the question of relativism. Perhaps we can discern in their own views an explanation of the elision of the problem of relativism, which is an epistemological problem regarding the nature of truth.

The authors conclude that, "Indeed while Foucault and Szasz proceed from quite different initial assumptions, both advance arguments against the activities of institutional psychiatry that are fundamentally *hortatory and value based*—not scientific—in nature." Interestingly, the au-

thors then bring forth their own perspective which is also most insistently values based, but, they argue that their stance, contrary to those of Szasz, Stevens, and Foucault, *is both values based and scientific.* How do they justify this stance? To pursue this question, we turn to the next section of "Getting It From Both Sides."

The next section is called "Facts and Values in Psychiatry: Some Qualifications." This section, to a greater degree than the next one, their conclusion, presents the authors own views regarding the future of psychiatric nosology. The authors argue that though they acknowledge the necessity for a values based psychiatry, they depart from anti-foundationalism of Foucault and others in insisting that a values orientation in no way conflicts with the necessity to ascertain facts about mental disorders.

In the context of the present discussion, the most salient aspect of this section is that the authors simply presuppose the concept of "fact" as philosophically clear and distinct and therefore as a valid construct for psychiatry. And yet, the coherence of the concept of fact is one of the most discussed and debated notions in philosophy of science and in philosophy in its entirety. Philosophy of science, including the work of Popper and Kuhn, has shown that facts are always theory laden and cannot be understood decontextualized from a theory, whether physicalist, materialist, hybrid, idealist or whatever.[1] The authors point out and accept that, contrary to the claims of supporters of the medical model, there is no value free science; but science also can never be theory-neutral. Yet, the authors write with remarkable aplomb that their theory is scientific because, while it recognizes the inseparability of value theories and value judgments from psychiatric diagnoses and treatment, unlike postmodernist anti-foundationalist theories it recognizes the necessity of facts. Yet, at no point in their essay do the authors even hint that the nature and existence of facts is itself a very charged and profound philosophical question, one that engages ontology and epistemology, as well as ethics. In this way, too, the authors elide discussion of the ontological and epistemological issues that one would engage in a critique of mainstream psychiatric theory and practice, including the nature and relevance of the DSM to that theory and practice. As is well known, DSM was originally inspired by the logical empiricism of Carl Hempel and the operationalism of A. Rappaport.

Above, I stated that the authors do not raise the question of relativism as a critique of postmodern thought. Why not? Perspectival relativism, narrative relativism, or relativism in any form, if valid, renders science and reason irrelevant at best. The authors do point out in their discussion of Foucault that for him, "'Truth' therefore, cannot be absolute and claims of objectivity are impossible." However, nowhere in their article do the authors indicate that they believe that psychiatry should seek a truth that is "absolute," nor do they discuss the problem of relativism.[2] They do indeed believe that 'facts' are 'objective,' certainly in the sense that they are based on empirical observation allegedly unclouded by ideology. Be this as it may, the question of relativism is most germane to the authors' discussion of the role of values in their effort to "reform" psychiatric nosology.

The authors rightly focus on the fundamental value of the medical and mental health professions: health. In the following discussion, I should not be taken at all to be questioning the view that psychiatry is grounded in the value of health. On the contrary, I fully support this view and consider it to be vital to the continuance and theoretical and practical development of psychiatry and all of the mental health professions. Of course, what is considered to be "health" is, as the authors point out, a judgment. The authors also point out that the "DSM-IV-TR appendix, the Global Assessment of Relational Functioning Axis (5) can be seen as an attempt to operationalize psychiatric values…" The question arises then, if psychiatric values are based on judgment, are they not relative to, for example, culture or historical period? And, if they are relative, what motivates psychiatrists who are scientists to prefer one judgment to another, as to what, for example, constitutes health? The authors provide the example of someone who is diagnosed with "spinal disease," specifically a "fracture-dislocation of the lumbar vertebrae." The effort to restore this patient's ability to walk reflects the judgment that it is better to be able to walk than not to be able to walk. This judgment is fused with the facts that will enable efforts to restore the patient's ability to walk. Thus, the goal is to restore the patient's functioning to normalcy. The authors maintain that this example is generalizable to mental disorders like schizophrenia. The goal would be to restore the patient to health, to the ability to function normally or as close to normally as possible.

The problem with these formulations is that if one wants to develop a philosophically rigorous standpoint, and it seems to me that without such an effort, there is no philosophy at all—it is either rigorous or it is not philosophy—*and this is the fundamental homology between philosophy and science*—then one cannot sidestep the problem of relativism. Why are my or anyone else's judgments regarding what is good and bad with respect to health more worthy than anyone else's judgments?

The authors themselves cite an example of a hypothetical group who "valued paralysis and devalued walking" so that for them paraplegia would not constitute 'pathology.' Or, to put the point another way, why does paraplegia violate our sense of the meaning of health but not theirs? Are the views ethically and morally equivalent? And, most importantly, is our concept of health intrinsically different from theirs?

Philosophically considered, there are two aspects to the refutation of relativism: first, relativism, the view that everything is relative, is false because it is self-contradictory in excluding the principle of relativism itself from being relative. Second, the only way to preclude relativism, that is to say, to preclude holding an inherently self-contradictory position, is to show that,

in this case the concept of health, *is relative to that which is not itself relative*—that is to say to a transindividual, transcultural, transhistorical universal value that obtains for all in virtue of our existence as human beings. We do not know the ultimate meaning of the concept, but we seek to know that meaning and cannot not seek to know. However, the authors discuss health as the fundamental value of psychiatry, but they do not ask whether or not the concept of health as such, as a concept, can be relative in the sense of relativism and therefore be devoid of universality. What is the relevance of Husserlian phenomenology to the question or problem of relativism?

Phenomenologically, philosophy is a rigorous science that begins with the understanding that we as finite beings cannot know the ultimate ontology of the world, and therefore we adopt the standpoint of radical empiricism and investigate the world, including ourselves, just as it gives itself, with no ontological presuppositions. The phenomenological attitude is not tantamount to sidestepping the question of ontology. Much the rather, it is the fully conscious, intentional acknowledgement of human finitude in just this sense: since whatever we know or can know must be known in and through our minds, subjectivity, or consciousness, we cannot know whether or not anything exists independently of us; therefore, the most rational standpoint is to suspend judgment regarding the ultimate ontology of the world. From this point of view, everything is not relative in the sense of relativism which denudes everything of meaning; rather, everything is relative to the a priori of possible meanings for us as human beings.[3] For psychiatry to adopt this standpoint would be revolutionary, and, it would be a bloodless revolution! Actually, it seems to me that the authors of the paper under discussion here would find a home in phenomenology for their approach. I say this because they seem to be in crisis regarding the problem of ontology.

Endnotes

1. The best summary of the modern history of philosophy of science is A. F. Chalmers' bestselling book**,** *What is this thing called science?* Queensland: University of Queensland Press. The revised edition was published in 1999, but I prefer the earlier editions.

2. I discuss the problem of relativism in philosophy of psychiatry and psychoanalysis extensively in: Marilyn Nissim-Sabat (forthcoming, 2013) "Race and Gender in Philosophy of Psychiatry: Science, Relativism, and Psychiatry" in: *Handbook of Philosophy of Psychiatry*, ed. by K. W. M. Fulford and R. Gibbs, Oxford: Oxford University Press.

3. Though all of Husserl's works are germane to this issue, his last, and greatest work is the best starting point: E. Husserl (1970)*The Crisis of European Science and Transcendental Phenomenology*, trans. by David Carr (Evanston, IL: Northwestern University Press).

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Critiquing Psychiatry: How We Do It

James Phillips, M.D.

A Predicament

In *Getting it From Both Sides,* the authors have given us a thorough review of critiques of psychiatry, a proposed division of the critiques into foundational and anti-foundational camps, and an admirable effort to refute the critiques. In this commentary I focus on my personal difficulties locating myself in these divisions, and what that may suggest about a need to broaden the divisions

Let me hone in on my difficulty by citing the authors' (cited) list of "underlying" ideas of the Enlightenment.

1. There is a stable, coherent, knowable self that is conscious and rational.

2. This self knows itself and the world through reason, which is the highest –and only "objective"—form of mental functioning.

3. The mode of knowing produced by the objective rational self is "science," which can provide universal truths about the world, regardless of the knower's perspective.

4. Such knowledge and truth produced by science will inevitably lead toward progress and improvement.

5. Language is rational, in that it represents the real/perceivable world which the rational mind observes
.

6. Language embodies a firm and objective connection between the objects of perception and the words used to name them (between signifier and signified).

In the unqualified way in which these ideas are presented, I would disagree with every one of them. What does this mean? That I'm a post-modern relativist? That I'm an anti-foundationalist? That I'm not a logical positivist? I certainly don't think of myself as a post-modern relativist. I also don't think of myself as a logical positivist. And while I might qualify myself as an anti-foundationalist, I like to think that my anti-foundationalism doesn't carry the baggage the designation does for the authors. That may be the crux of my discomfort.

In their introduction the authors state that "The aim of the present paper is to place the critics of psychiatric theory and practice in the broader framework of two philosophical traditions: *logical positivism* and *post-modernism.*" They fold these into the larger categories of foundationalism and anti-foundationalism – leaving us with a question. Is the implicit, unstated, theme of the paper that there are two choices available to us: recognition of the reality of psychiatric disorders based on a philosophical position of foundational logical positivism, versus rejection of the reality of psychiatric disorders based on a philosophical position of post-modern relativism? The issue here is to what an extent the categories of logical positivism and port-modernism map onto the other categories of foundationalism and anti-foundationalism. Can one be a foundationalist but not a logical positivist? And can one be an anti-foundationalist

but not a post-modernist? And to bring these questions directly to bear on the theme of the article: where in all this is there room for an acknowledgment of the reality of psychiatric disorders that is not logical positivist and not foundational? That is the question I raise in this commentary.

Foundationalism and Anti-foundationalism

According to the authors, "*foundational* philosophies and philosophers hold that we can *reliably describe a coherent, objectively-measurable* '*reality*' or '*truth*', whether one considers the world as a whole, or specific aspects of it, such as the classification of disease. *Anti-foundational* philosophies and philosophers deny this claim, asserting that there are no objectively demonstrable 'truths', – only various 'perspectives' or 'narratives' that cannot be privileged as uniquely or objectively 'true'."

Although the authors invoke ancient examples of skepticism, as well as Augustine, as defenders of foundationalism, would it be fair to argue that the foundationalism debate is an affair of the modern era, with its origin perhaps in late medieval nominalism, its first dramatic expression in Descartes, and its flowering in reactions to 17th rationalism and the Enlightenment? But then who are the foundationalists and who are the anti-foundationalists? The authors name the easy candidates: Descartes and the logical positivists representing the rationalist and empiricists wings of foundationalism; post-modern figures like Foucault and Derrida representing anti-foundationalism. What about Kant? Is he a foundationalist or anti-foundationalist? The apriori categories are foundational, but the thing-in-itself is an unknowable reality. How about Hegel? In the phenomenological tradition, Husserl's goal was certainly foundational, but Merleau-Ponty stands out for rejecting that position, insisting that our contact with the world involves a realist (?foundational) and an idealist (?anti-foundational) dimension, and that either fails on its own. His philosophy is developed around the core insight that consciousness and world form an indissoluble unity. As he writes: "The world is inseparable from the subject, but from a subject which is nothing but a project of the world, and the subject is inseparable from the world, but from a world which it projects itself" (Merleau-Ponty 1962 [1945], p, 430). Is this foundationalist or anti-foundationalist? Both and neither.

Let me turn to Gadamer (Gadamer 1975 [1960]), another philosopher who challenges the foundationalist-anti-foundationalist division. He is also of interest because he brings the topic of hermeneutics into the discussion. Gadamer's position is that we always approach an issue – e.g. a historical event, a philosophical question – with preconceptions—our "horizon of understanding"—and that we oppose our horizon to that of the interpreter at the time of the event or earlier discussion, the result being a fusion of horizons in which our own perspective or preconception is altered and our understanding deepened. The "truth" is a historically conditioned and ever evolving process. In the language of the authors this is of course an issue of "perspectives" or "narratives," and thus anti-foundational. But that is not a fair representation of the hermeneutic approach. Or it only anti-foundational if your standard is something like: either verifiable, no-holds-barred objective truth, or hopeless relativism in which all perspectives enjoy equal status. Nietzsche may be the one philosopher who mischievously argued for unassailability of perspectives, but he is not representative of the Gadamerian hermeneutic tradition, in which knowledge advances through dialogue and the confrontation of perspectives.

Invoking Gadamer and hermeneutics of course brings me to Thomas Kuhn, who wrote that "…the discovery of hermeneutics did more than make history seem consequential. Its immediate and decisive effect was instead on my view of science" (1977, p. xiii). The authors place Kuhn in the anti-foundational camp, keeping company with Nietzsche, Foucault, and Derrida. Let's allow Kuhn to address that assignation:

> One consequence of the position just outlined has particularly bothered a number of my critics. They find my viewpoint relativistic, particularly as it is developed in the last section of this book….Later scientific theories are better than earlier ones for solving puzzles in the often quite different environments to which they are applied. That is not a relativist's position, and it displays the sense in which I am a convinced believer in scientific progress.

Compared with the notion of progress most prevalent among both philosophers of science and laymen, however, this position lacks an essential element. A scientific theory is usually felt to be better than its predecessors not only in the sense that it is a better instrument for discovering and solving puzzles but also because it is somehow a better representation of what nature is really like. One often hears that successive theories grow ever closer to, or approximate more and more to, the truth. Apparently generalizations like that refer not to the puzzle-solutions and the concrete predictions derived from a theory but rather to its ontology, to the match, that is, between the entities with which the theory populates nature and what is "really there."

Perhaps there is some other way of salvaging the notion of 'truth' for application to whole theories, but this one will not do. There is, I think, no theory-independent way to reconstruct phrases like 'really there'; the notion of a match between the ontology of a theory and its 'real' counterpart in nature now seems to me illusive in principle. Besides, as a historian, I am impressed with the implausibility of the view. I do not doubt, for example, that Newton's mechanics improves on Aristotle's and that Einstein's improves on Newton's as instruments for puzzle-solving. But I can see in their succession no coherent direction of ontological development. On the contrary, in some important respects, though by no means in all, Einstein's general theory of relativity is closer to Aristotle's than either of them is to Newton's. Though the temptation to describe that position as relativistic is understandable, the description seems to be wrong. Conversely, if the position be relativism, I cannot see that the

> relativist loses anything needed to account for the nature and development of the sciences. (Kuhn 1970, pp. 205-207).

I think it's fair to say that Kuhn jumbles the authors' categories. He's anti-foundationalist, but not relativist. He believes in scientific progress, and in the notion that one scientific theory is better than another, but not in the notion that science reaches some kind of final, uninterpreted, unmediated truth. Or I could say that he's foundationalist, but not in the sense of reaching an unvarnished, bedrock reality through science.

Psychiatric Reality

Let me now break off from invoking this gallery of foundationalist/anti-foundationalist hybrids (I have, after all, spared you Heidegger and Wittgenstein), and get to the matter of psychiatry. The authors divide the strong critics of psychiatry (strong enough to be labeled anti-psychiatrists) into foundationalist and anti-foundationalist camps (or logical positivist and post-modern camps). This division leads to an implicit conclusion that defending the reality of psychiatric disorders involves some kind of modernist and logical positivist stance. Just as I am uncomfortable with the foundationalist/anti-foundationalist division, so I am uncomfortable with the implicit conclusion that defending psychiatry requires Enlightment modernism plus logical positivism. (I may be misrepresenting this as the implicit position of the authors, but then I'm not sure what their position is.)

I wish to draw a different conclusion from that which I am attributing to the authors, and I begin with the last sentence in the citation by Kuhn: "Conversely, if the position be relativism, I cannot see that the relativist loses anything needed to account for the nature and development of the sciences." In other words, is anything lost in defending psychiatry with the hybrid philosophical position represented by Kuhn and others mentioned above. I would in fact take this a step further and argue that the movement of contemporary psychiatry is not in the direction of modernist/positivist position but rather in that of the hybrid of Kuhn and others. This is manifest in the current DSM-5 debates. If you want a model of the modernist/positivist position, you have it in the Robins/Guze criteria for diagnostic validity and their instantiation in DSM-III and DSM-IV. Now we of course know that DSM-III/IV diagnoses have failed the validity tests, and with that failure we have witnessed the collapse of the dream of neat positivist diagnostic boxes: disorders with clean genetic and physiological foundations. We are moving in fact to something very different: diagnostic categories that will probably require understanding in the language of complexity theory. To take the king of diagnoses, schizophrenia, how will we understand it? Will it be one category or 50 categories related in a variety of ways? Will it merge on a spectrum with bipolar disorder, and in what ways? Most importantly, will we understand it in different ways for different purposes? If our goal is homogeneous genetic or physiological grouping, we may aggregate the various phenotypic expressions in one way; if on the other hand, our interest is response to treatment, that might require a different aggregation. There is simply no reason to expect that in the vast population we now label schizophrenia, the aggregations dictated by different purposes will map onto one another. If this is the case we will be left with the question: what do we call schizophrenia, and for what reason, and can we even define a superordinate category that justifies retention of the diagnostic category? What we now call schizophrenia spectrum disorders is simple flag-waving for what we don't know. I add forcefully that this line of thinking is not remotely to be confused with anti-psychiatry. It is simply a recognition of the complexity of the very real psychopathology we deal with.

I am aware that in their response to this commentary the authors might retort that I am imputing to them a point of view that they don't lay claim to, that all they are doing is dividing anti-psychiatry into logical positivist and post-modern positions, and trying to defend psychiatry from both kinds of attack. My only response to such a retort would be that I have tried to take the discussion in a different direction, with an argument that the foundationalist/anti-foundationalist division is unsatisfactory, and that a defense of psychiatry will stand on firmer ground if based on what I have been calling a hybrid model than on a foundationalist or positivist model.

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Psychiatric Reform: Mining Critique for Philosophical Resources

Douglas Porter M.D.

The authors of "Getting It from Both Sides: Foundational and Anti-Foundational Critiques of Psychiatry" do the philosophy of psychiatry a service with their article. They wisely caution against the "if you are not with us, you are against us" attitude that equates critique of psychiatry with being "anti-psychiatry". Such an attitude prevents appreciation of beneficial teaching moments in critique that have the potential to stimulate progressive psychiatric reform. Indeed, it is concern for the content and meaning of critical arguments that leads the authors to carefully unpack and differentiate the philosophical assumptions that guide Foucault and Szasz, while less careful analysis would lump them together as just so many equivalent instantiations of anti-psychiatry.

The authors note that while Szasz contributes to psychiatry by pointing

toward the very real potential for abuse of power in the practice of psychiatry, he ultimately undermines the significance of his critique by stubbornly clinging to a positivist philosophical orientation. This philosophical orientation ignores the implicit value judgments associated with biological medicine and, as the authors point out, perpetuates the myth that adding values entails subtracting facts. Foucault, on the other hand, could certainly not be accused of adopting a positivist philosophical orientation. Within Foucault's "archeology" of knowledge, traditional biologically oriented medicine becomes just another discursive formation of knowledge/power that does not differ substantially in form from that of psychiatry (1). In fact, this kind of "anti-foundational" leveling of the discursive playing field can be seen as undermining the kind of normative foundation that is required for progressive form. The questions Foucault self-consciously asks of science are not, "the possible use or misuse to which it can be put", but instead merely, "the question of its functioning as a discursive practice and of its functioning among other practices" (2).

Nonetheless, Foucault's concern about the repressive aspects of societal exclusion of the mentally ill is evident in his book "Madness and Civilization" (3). Foucault's concerns in this regard and the more general postmodern celebration of difference can be seen as a progressive philosophical influence in certain civil rights movements. These movements underscore the fact that much of the suffering associated with mental and other forms of chronic illness does not result directly from the illnesses but rather from society's response to, and failure to accommodate, differences associated with the illnesses. But, in terms of the suffering inherent in illness and the fact that the discourses of medicine and psychiatry may be more or less in tune with the call to action that is created by that suffering, it seems to me that Foucault's archeological method can most generously be regarded as simply remaining mute. Perhaps the call to resist the trap of objectifications created by discursive formations in psychiatry can be seen merely as a cautionary note against the reification of our pragmatic diagnostic constructs, in which case postmodernism has become a kind of common sense amongst current practitioners of the philosophy of psychiatry (and hopefully amongst current practitioners of psychiatry). But, less generously, the portrayal of alternative discursive formations as just so many equivalent instantiations of knowledge/power can be seen as an invitation to the type of moral skepticism and relativism that ultimately undermines progressive reform. I think Foucault can be interpreted as joining ranks with Szasz in implying that evidence that psychiatric discourse is value-laden is tantamount to evidence of its illegitimacy. The complex interplay of facts and values that eventually become entwined in psychiatric discourse can be resolved for the better or for the worse. Not only can psychiatric discourse be more or less factual, it can be more or less ethical. The power evinced by psychiatric discourse may be more or less in the service of those who are living with mental illness. This does not appear to concern Szasz or Foucault.

A responsible medical response to the suffering created by illness entails maintaining a normative stance; there is simply no room for a stance of moral skepticism. It is perhaps, then, not so ironic that when Foucault does take a normative stance about the misuse of power he employs medical metaphors. He makes reference to "pathological forms" of power and even "diseases of power" (4). Taking a normative stance about pathological forms of power is laudable, but it appears awkward within Foucault's philosophical system which limits itself to unpacking the historical formation of scientific objects of discourse while abstaining from judgments about their proper use or misuse. The authors of "Getting It from Both Sides: Foundational and Anti-Foundational Critiques of Psychiatry" recognize that a complex interplay of factual and evaluative elements evolves in psychiatric discourse. This recognition, dealt with responsibly, entails an effort to insure that the power evinced by psychiatry is properly regarded as therapeutic as opposed to pathological. Alas, in terms of providing philosophical resources to guide the development of a more therapeutic and less pathological psychiatric discourse, the critiques provided by Szasz and Foucault appear very limited.

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Why Taxonomise Anti-psychiatry?

Tim Thornton, Ph.D.

Of all disciplines, psychiatry is particularly keenly aware of the importance of a good taxonomy. Whilst in some scientific disciplines the explicit focus is on explanatory theories and there is only implicit attention to the taxonomies they presuppose, in psychiatry, getting the taxonomy right is one of the key foci of intellectual endeavour. This attention has helped reveal different virtues of taxonomies. Thus until recently, the key virtue aimed at for the DSM taxonomy has been reliability: roughly, the non-collusive agreement in applications of the taxonomy in classificatory judgements.

For DSM-5, the key aim is, we are

told, validity. But even validity can be subdivided. It might mean, for example, any of these or others:

- *Face validity*: the extent to which a classification appears to be of relevant features (which has consequences for the acceptability of tests to test users and subjects [Rust and Golombok 1989: 78]).

- *Construct validity*: roughly, the extent to which it relates to underlying theory. Kendell articulates this thus: 'the demonstration that aspects of psychopathology which can be measured objectively… do in fact occur in the presence of diagnoses which assume their presence and not in the presence of those which assume their absence' [Kendell 1975: 40]. Anastasi says it is 'the extent to which the test may be said to measure a theoretical construct or trait' [Anastasi 1968: 114].

- *Predictive validity*: the extent to which the classification allows us to predict future properties.

- *Content validity*: 'the demonstration that the defining characteristics of a given disorder are indeed enquired into and elicited before that diagnosis is made' [Kendell 1975: 40].

So it is appropriate in thinking about a proposed taxonomy of forms of criticism of psychiatry – forms of anti-psychiatry – to examine the intellectual virtue of the proposal in something of the same spirit as critical reflection of psychiatric taxonomy itself. In this case, my concern is not so much whether anti-psychiatry can be divided into forms which are foundational and forms which are anti-foundational (although I do have worries about quite how this is proposed). It is rather whether we learn anything from doing that. I am not sure that we do.

An initial requirement for the taxonomy

I can illustrate one challenge to a taxonomy of this sort by looking at the business the paper sets itself. Called 'Getting it from both sides' it says:

The burden of this paper will be to outline the historical roots of foundational and anti-foundational philosophies; describe how these philosophies have provided the basis for a "double-barreled" assault on modern-day psychiatry…

A key theme is that psychiatry is criticised from both sides of a distinction. This sets up a particular kind of expectation about the significance of the duality that forms the taxonomy which I will illustrate indirectly.

One way to fail to meet the expectation would be to propose a taxonomy of forms of anti-psychiatry based on the position in the alphabet of the first letter of the first author of the attack. If this were a simple duality – of first half versus second half – then (given the names 'Foucault' and 'Szasz', eg.), psychiatry would come under fire from both sides, a 'double-barreled' assault on modern-day psychiatry if you like. In that hypothetical case, there would, however, be no significance (such as, perhaps, a bitter irony) that psychiatry were attacked from both sides. Although the distinction is in one sense perfectly valid, and cuts anti-psychiatry at the joints of author nomenclature, it fails something like construct validity. It fits no deeper theory of anti-psychiatry.

So one test of the proposed taxonomy is that it does have significance. The ideas of foundationalism and anti-foundationalism should shed light on the nature of the anti-psychiatry in a way that mere surnames do not (because of the 'arbitrariness of the signifier' as Post-modernism, in particular, has taught us to say).

But there is a worry from a potential response to this. Suppose that from anti-foundationalist premises, a form of anti-psychiatry were justified, if followed logically. And from foundationalist premises, another form of anti-psychiatry were similarly justified. Then on the assumption that either foundationalism or anti-foundationalism is true, some form of anti-psychiatry would be justified come what may. So, as far as a defence of psychiatry goes, we had better hope that the relation of significance (between the category and anti-psychiatry) is not implied.

Whatever the kind of significance turns out to be, at the very least, some kind of light should be shed on anti-psychiatry by seeing it in the context of the taxonomy.

What is foundationalism?

The paper suggests that foundationalism has two key aspects. One is a traditional *epistemological* notion. Knowledge is based on a foundation (of experience, or belief) which is not itself (inferentially) dependent on anything else.

Logical positivism in its various forms is a modern-day expression of the foundational world-view... [It] essentially held that all knowledge is based on logical inference grounded in observable fact…

Foundationalism, in this traditional epistemological sense, is usually held to contrast with forms of holism which deny that any of our beliefs, such as perceptual beliefs, are privileged and instead each is potentially subject to revision. A belief in the theory dependence of observation is one reason to support holism in the philosophy of science.

The other aspect is expressed in this way:

In simplest terms, foundational *philosophies and philosophers hold that we can* reliably describe a coherent, objectively-measurable "reality" or "truth," *whether one considers the world as a whole, or specific aspects of it, such as the classification of disease.* Anti-foundational *philosophies and philosophers deny this claim, asserting that there are no objectively demonstrable "truths"—only various "perspectives" or "narratives" that cannot be privileged as uniquely or objectively "true."*

(It may not be quite realism in a standard form, however, since the most obvious opposition to ontological realism is idealism, whilst the authors take Berkeley to be a foundationalist: 'Berkeley effectively dispensed with the concept of material substance, but most certainly was a foundational philosopher: he merely argued that the "foundation" of reality consisted of ideas in the mind of God!' But even in this case, the idea may be that whatever the substrate of the world, it is independent of claims made about it. That serves as a test of truth and thus stands in contrast with the anti-foundationalists' mere interplay of narrative.)

There is some danger in combining

both these aspects – epistemological and ontological – under a single term which can be illustrated by a philosopher mentioned in the paper: Quine. In his famous paper 'Two dogmas of empiricism' Quine explicilty rejects the idea of foundations when he rejects the' dogma of reductionism' which is the 'supposition that each statement, taken in isolation from its fellows, can admit of confirmation or infirmation at all'. [Quine 1953: 41] But he continues 'My counter suggestion… is that our statements about the external world face the tribunal of sense experience not individually but only as a corporate body.' So whilst he rejects privileged epistemological foundations he does not reject the idea that our beliefs answer to something independent of us.

This is significant because that combination of ideas is the dominant view held by philosophers and self-conscious scientists alike. Epistemological foundationalism is dead. No observation is thought to be free of its theoretical context and thus, like any scientific statement, is fallible. But rejecting that view does not commit one to a denial that our beliefs answer to a world largely independent of us, nor to the embrace of mere shifting narratives.

Given that the taxonomy is offered, not for philosophy as a whole, but rather for anti-psychiatry, it might be that no anti-psychiatrist fails to combine the appropriate epistemological and ontological views. But if the taxonomy is to shed light on anti-psychiatry, such correlations should be explicit and subject to explanation rather than hidden in the taxonomy.

The application of the taxonomy

Having set up the taxonomy, the authors apply it to particular critics of psychiatry. I will discuss just the first: Szasz. Responding to a recent summary by Szasz of his original argument they say:

A full-blown critique of this argument is beyond the scope of this paper. However, it is instructive to note some of the key "properties" of Szasz's claim: (1) It is based on an implicit assertion that "analytic truths" are not empirically falsifiable—a claim that Quine is at pains to challenge; (2) It appears to remove from the realm of scientific investigation the question of whether schizophrenia or bipolar disorder, for example, are diseases or illnesses; (3) It conflates the terms "disease","illness", and "disorder" without any attempt to discern conceptual or clinical distinctions among them; and (4) It implies that there is a single, univocal "materialist-scientific definition of illness" to which one can appeal, and which then can be used unambiguously to compose an "analytic truth." Also note that the hyphenated term "materialist-scientific" implicitly suggests that science and "materialism"—roughly, the view that the only thing that exists is "matter"—are linked in some essential way.

In the context of a paper suggesting a categorisation of anti-psychiatry, I would expect that this list would demonstrate how Szasz fits his assigned place: foundationalism. And indeed, pace my worries about Quine, the first point does. Szasz is within a tradition of philosophy which accepts analytic truths and Quine, at least, has argued that this is an important part of foundationlism. Point 2 does not obviously exemplify the category but, perhaps, neither does it contradict it. Point 3 seems to lie simply outside the terms of the taxonomy. One might be guilty of this which ever side one belonged to. Likewise, point 4 does not seem to be an effect of or have anything to do with foundationlism.

That is a bit odd. Only the first point helps locate Szasz on the foundationalist side of the taxonomy.

There is then an argument against Szasz. In a paper outlining a taxonomy, such an argument is not the main business. But it may illustrate what we learn from applying the taxonomy and thus why the taxonomy is helpful. The central argument runs:

Szasz's argument purports to rest upon an analytic *statement—similar in kind to "All bachelors are unmarried males"*—while implicitly drawing upon the historical and empirical claims of "materialist" science. *Yet any putative "materialist-scientific definition of illness"—to the extent we can even specify one—did not arise* ex nihilo *or out of some syllogism; but rather, from specific* empirical observations *of cells, tissues and organs, by pathologists like Virchow and von Rokitansky. Thus, Szasz's argument that "mental illness is a metaphor" seems to us far from a straightforward "analytic" claim; rather, it appears to be a* pseudo-*analytic claim that depends critically on a huge body of historical, synthetic and empirical claims.*

One way of approaching this argument is to think that it helps demonstrate the value of the taxonomy. If Szasz is a typical foundationalist and if typical foundationalists presuppose the analytic-synthetic distinction, but if that is an invalid distinction (as Quine has argued), then Szasz' argument will fail and it will fail because he is a foundationalist. That would be a partial vindication for the taxonomy. Putting him into that camp helps shed light on why he is wrong.

But it is not clear that that is what the authors intend here. The comment that Szasz' claim is 'far from a straightforward "analytic" claim; rather, it appears to be a pseudo-analytic' suggests that an analytic claim might be in perfectly good order. The problem is not so much that Szasz is appealing to the notion an analytic truth, rather, he is doing that badly. If so, the problem with Szasz' anti-psychiatry is not that it is foundationalist but that it is bad foundationalism. But if that is the case, the taxonomy of anti-psychiatry into foundationalism and anti-foundationism does not seem to be carving the nature of anti-psychiatry at the right – significant, informative – joint.

It is also worth noting that if that is not the meaning of that phrase and that any appeal to analyticity is misguided (thus preserving the point of the taxonomy for the foundationalist side), the key architect of the downfall of analyticity is Quine whom the authors call an anti-foundationlist. So why would not the failure of foundationalist anti-psychiatry be a partial argument, at least, for the success of an anti-

foundationalist variant? In fact in the later parts of the paper, anti-foundationalist anti-psychiatry is criticised on grounds which do not even mention analyticity. Thus no light is shed on criticisms of anti-foundationalists in virtue of their analyticity-eschewing position in the taxonomy. In either case, at least one side of the taxonomy will not be informative.

A different taxonomy?

I think that it is a mistake to hope that a binary opposition which locates forms of anti-psychiatry on both sides will, in itself, be very helpful. How could it? If a binary distinction exhausts logical possibilities – if everything is either in the one or the other category – then all the positions we can take will be in one or the other. All forms of philosophical view which support modern psychiatry will be located rubbing up against the views which oppose them. The taxonomy will not shed light on the difference between the pro- and anti- view.

I think that a more fruitful approach is a taxonomy of approaches to the nature of mental illness itself. Here are two, related distinctions.

One key disagreement is whether mental illness in particular, or illness more generally, is essentially evaluative. Does the analysis of mental illness contain reference to values or not? Some philosophers and psychiatrists argue that at the heart of the idea of illness is something that is either bad for a sufferer or is a deviation from a social or moral norm. Both of these are evaluative notions and hence both are 'values in' views.

Others argue that it is, what I will call, a plainly factual matter. Typically, they argue that illness involves a failure of a biological function and function – and hence deviation from, or failure of, function – is a plainly factual, biological term couched in evolutionary theory. Of course, disagreement about the presence or absence of values in the analysis is just one aspect of the debate. It is a further question, for example, what follows from this for the objectivity of mental illness and the status of psychiatry as a science. For Szasz this is the basis of an argument against psychiatry. For Bill Fulford (and the authors of the paper), for example, it is not.

A second useful characterisation links the debate about mental illness to other debates in philosophy about the place in nature of problematic concepts. On this second construal, the question is whether mental illness can be *naturalised*. That is, can mental illness be accommodated within a satisfactory conception of the natural realm?

The most common form of philosophical naturalism is reductionism which attempts to show the place in our conception of nature of puzzling concepts by explaining them in terms of, and so reducing them to, basic concepts that are unproblematically natural. So on this second characterisation of the debate, a pressing question is whether, or to what extent, the concept of mental illness can be reduced to plainly factual concepts. If it cannot be naturalised, to what extent is it consistent with a scientific account of the world.?

What makes reductionism difficult is that different concepts can seem to behave quite differently from one another. Take, for example, a distinction drawn from the work of the philosopher Wilfrid Sellars, and repopularised by John McDowell [McDowell 1994] between the 'realm of law' and the 'space of reasons'. Whilst the space of reasons concerns meaning-laden and normative phenomena that we take for granted in understanding minds, the realm of law concerns events that can be explained by subsuming them under natural scientific laws. In the philosophy of mind, reductionists attempt to show how the space of reasons can be completely explained using the resources of the realm of law. Anti-reductionists argue that the normativity of mental states and meanings – the fact that beliefs can rationalise and support one another, can be right or wrong – cannot be captured in terms, for example, of statistical laws of association.

In fact, value theorists in the debate about mental illness are making a similar point to anti-reductionists in the philosophy of mind. They argue that the very idea of mental illness is a normative notion – since values are normative and have a good versus bad dimension – and for that reason cannot be reduced to plainly factual or realm of law terms.

Using distinctions such as these provides tools for the diagnosis of assumptions made both by those who oppose and those who support modern psychiatry. In the paper, the authors criticise one 'foundationalist' anti-psychiatrist in this way:

Stevens' foundational critique is built upon a scaffolding of selective quotes from a large cadre of mental health professionals... all in the service of showing that we cannot identify any biological abnormalities *in any of the major psychiatric disorders; and that,* absent such physical "causes," these conditions cannot be considered bona fide diseases.

Whilst I agree with the criticism they go on to make, I do not think that it helps to characterise Stevens as a foundationalist. The quotation does not imply anything about his epistemological views nor would ontological realism about an objective world help shed light on his particular brand of anti-psychiatry.

What is picked out in the quotation is an assumption that he has made about what counts as real: biological abnormalities. And thus he counts as both 'values out' and reductionist in the two distinctions above. This is not yet to provide an argument against his position. But it does help outline the commitments he needs to maintain. He owes an account of why biological abnormalities are all that can count as real in this context. A biologically minded reductionist supporter of modern psychiatry will agree with Stevens on that metaphysical claim and will have to look elsewhere to disagree. But an anti-reductionist supporter of psychiatry can target that assumption. The assumption – and hence his reductionism – sheds light on his position.

In sum, I think it a mistake to aim a taxonomy at anti-psychiatry rather than at views of mental health and illness (or disease or disorder) in general. It will probably, at least, not be particularly helpful. If the aim is, additionally,

to attempt to undermine anti-psychiatry, then it seems doubly mistaken because it cannot work. If – and this is a key assumption – we were to assume, from the perspective of a defender of contemporary psychiatry, that anti-psychiatry were simply misguided then a helpful analogy might be with Tolstoy's views of unhappy families in Anna Karenina. There is little point in aiming to taxonomise arguments against psychiatry because whilst valid views in support of psychiatry are all alike; every unhappy anti-psychiatric argument is unhappy in its own way. But to evaluate that key antecedent assumption, we will need valid general taxonomies of views of health and illness and nature in general.

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Replies to Comments on "Getting it from Both Sides"

Ronald Pies, SairahThommi, and Nassir Ghaemi

"…however much you deny the truth, the truth goes on existing, as it were, behind your back…"-- George Orwell, from *Looking Back on the Spanish War*

We very much appreciate the thoughtful comments of our reviewers. While we can't respond to all the issues they raise, we hope the following comments are at least a provisional response to some of the more salient points of contention.

Reply to Jeffrey Bedrick, M.A., M.D.

Our thanks to Dr. Bedrick for raising some important and interesting questions regarding our paper. Dr. Bedrick writes, "I think even before the recent paper [on ALS], any neurologist would have been extremely uncomfortable if we had said to them that the underlying pathophysiology of ALS could never be discovered, or even further, that there was no underlying biological pathophysiology to be discovered. Do we feel the same way about schizophrenia? About posttraumatic stress disorder? Borderline personality disorder?"

But we would not make such an argument. We would argue only that we need not possess *at this time* such pathophysiological knowledge in order to defend the claim that schizophrenia or PTSD are instantiations of "disease".

Dr. Bedrick writes, "The authors go on to say that "'disease' is properly predicated of *persons* ('people')—not of minds, brains, bodies, tissues or organs." I would imagine that those who study the diseases of plants might find this a strange claim." Of course, we realize there are many *non-human* contexts in which the term "disease" is used, and in which the term has coherent meaning and utility. We were speaking in the context of human disease states, and following the general argument of psychiatrist RE Kendell; i.e., "Neither minds nor bodies suffer from diseases. Only people (or, in a wider context, organisms) do so…" [see RE Kendell in *Szasz Under Fire*, op cit, p. 41]. Thus, contra Szasz and consistent with Kendell, we would deny that—in ordinary language-- human *cadavers* can be in a state of illness or "disease" (as in, "That cadaver has a very serious disease!"), though a cadaver may indeed demonstrate *organ, tissue or cellular pathology*. [See footnote on Virchow**] On linguistic grounds, just as a heart or brain cannot have "ease", neither organ--on our view and that of Kendell--ought to be characterized as having "dis-ease." We acknowledge, however, that pathologists do sometimes speak of a "badly diseased heart" and of "diseased brains" and that our argument is itself subject to a counter-argument from "ordinary language"—at least, as ordinarily spoken by pathologists! Nonetheless, we stand by our position that the term "disease" is most useful in ordinary discourse—and in clinical psychiatry--when applied to (human) *persons.*

Dr Bedrick writes, "I think psychiatry can be defended against its critics. Doing so, however, I think entails acknowledging some differences between psychiatry and other branches of medicine. That there are such differences is not a weakness for psychiatry. It is rather a strength of psychiatry as a branch of medicine that does deal with persons, both in their physical and mental aspects. There is much in the paper to commend it, but I think it weakens its own arguments by the refusal to consider the differences between psychiatry and other branches of medicine, and not just their similarities." We do not disagree with Dr. Bedrick that there are certain technical, methodological, and evidentiary differences between psychiatry and other branches of medicine, but we believe these differences have been greatly exaggerated by psychiatry's critics;

moreover, such differences as do differentiate psychiatry from other medical specialties mask many fundamental elements in common. To be sure, psychiatry, in some sense, partakes of science and art, objective and subjective elements [See Pies R: Can psychiatry be both a medical science and a healing art? Psychiatric Times , Oct. 19, 2011]. But in this regard, it does not differ fundamentally from much of general or internal medicine, which also deals with "persons, both in their physical and mental aspects." As Osler put it, ""The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head."

Reply to Michael A. Cerullo, M.D.

We thank Dr. Cerullo for his kind remarks on our paper. At the same time, we acknowledge that Dr. Cerullo is justified in pointing out our omission of an in-depth discussion of RD Laing ("While [Pies et al] focus on the writings of Michael Foucault and Thomas Szasz, one other writer of the period also needs to be included; R.D. Laing….these three writers laid the intellectual foundation for the antipsychiatry movement…"). Dr. Cerullo finds a common "core" to Szasz, Foucault and Laing; i.e., "an extreme form of ontological skepticism…[that denies the]….*objective* existence of mental illness. " Before replying directly, we will simply take note of Szasz's scathing critique of Laing, which suggests (from Szasz's perspective) anything but a common philosophical position; see, e.g., see: Szasz, T. (2008). Debunking antipsychiatry: Laing, law, and largactil. Existential Analysis, 19(2), 316-343, accessed at: http://findarticles.com/p/articles/mi_6881/is_2_19/ai_n31874753/; and the riposte offered by Brent Robbins, PhD, accessed at: http://www.szasz.com/critics.htm].

We would generally agree with Dr. Cerullo that the views of Szasz, Foucault and Laing all had the *effect* of undermining any notion of the "*objective* existence of mental illness", and that—for this reason—the three are often discussed (appropriately or not) under the rubric of "anti-psychiatry". And, if by "ontological skepticism", we mean that all three would likely answer "no" to the question, "Is there such a "thing" as mental illness, in the same sense that there is such a thing as sodium?", then, indeed—Dr. Cerullo is probably correct. But we still maintain that Szasz and Foucault begin with very different *epistemological assumptions* and beliefs; that is, beliefs about what can be "known" or claimed as matters of scientific fact. In our view, Szasz is very much the logical positivist when it comes to logical and epistemological claims about "disease"; Foucault is epistemologically skeptical, in the post-modern tradition.

Laing is a more complex case, perhaps, than either Szasz or Foucault . On the one hand, Laing is often thought of as both "post-modern" and "existential-phenomenological" in his approach to psychiatry and "mental illness." Indeed, psychiatrist Tony Benning, in an essay entitled, "Was R. D. Laing a Postmodern Psychiatrist?" concludes that, yes, Laing was in the post-modern tradition; for example, he noted Laing's "… repudiation of the privileged status of 'objective' over 'subjective' knowledge including his challenge of the claims of 'neutrality' of science, particularly… the role played by the observer's presence or intention and his emphasis on intersubjectivity…" [accessed at: http://www.soteria.freeuk.com/Laingpostmodern.htm].

On the other hand, one section of Laing's classic, The Divided Self", is entitled, " The existential-phenomenological foundations for a science of persons." Now, we believe the two key words in this phrase are "foundations" and "science". Laing, in our view, did not truly defend the post-modern position that "there is no truth" or that (a la Foucault) *all claims of genuine knowledge are merely pretexts for the imposition of control*. Indeed, he writes that

"A genuine science of personal existence must attempt to be as unbiased as possible. Physics and the other sciences of things must accord the *science of persons* the right to be unbiased in a way that is true to its own field of study." (italics ours; cited in *Selected Works of R.D. Laing*, vol 1, p. 24).

Furthermore, Laing did not deny that the term "schizophrenia" (or "schizophrenic" as a noun) could be applied legitimately to certain persons whose behaviors did not make sense to others, and which were idiosyncratic in certain characteristic ways. Rather, he challenged the idea that schizophrenia was best conceptualized as a *disease process*, in the way, say, that cancer is a disease process.

Thus, in *The Divided Self,* Laing describes a patient of Kraepelin, and notes, "...there is no question that this patient is showing the 'signs" of catatonic excitement. The construction we put on this behavior will, however, depend on the relationship we establish with the patient...it seems clear that this patient's behavior can be seen in at least two ways...one may see his behavior as 'signs' of a 'disease'; one may see his behavior as expressive of his existence."

Indeed, in the following passage by Laing, it is difficult to discern what Dr. Cerullo calls a "denial of the *objective* existence of mental illness." Laing states,

"The schizophrenic is desperate, is simply without hope. I have never known a schizophrenic who could say he was loved...We have to recognize all the time his distinctiveness and differentness, his separateness and loneliness and despair." (p. 38).

Laing's use of the phrase "*a* schizophrenic''—analogous to "a diabetic" or "an epileptic"—suggests that for Laing, there is a "reality" *of some kind* that underlies mental illness. But for Laing, the reality is to be understood in phenomenological-existential terms. In sum: Laing is "anti-foundational" in some crucial respects, as Benning suggests; but in other ways, Laing remains within the Western paradigm of foundational science—albeit within the "science of persons".

Reply to Bradley Lewis MD, PhD

We thank Dr. Lewis for expressing so clearly the primary rationale for our paper; i.e., the assumption that it is "… worthwhile for psychiatry to understand its critics and to bring that understanding inside the knowledge base of psychiatry." And, we fully agree with Dr. Lewis that our profession needs "… psychiatrists who have *thought through in advance* some of the key reasons people are unhappy with psychiatry and why many believe psychiatry can be harmful." That said, we would respectfully dissent from Dr. Lewis's view that our paper presents a "a sharp foundationalist/antifoudationalist dichotomy" that inadvertently "…slides into problematic stereotyping." Nor do we agree that our argument encourages psychiatrists to "…ignore the many subtleties of the philosophers and the many complaints of the critic", and to "go back to business as usual in psychiatry."

Alas, "business as usual" for many psychiatrists these days *already* ignores philosophical subtleties—both those that undergird the basis of psychiatric practice, and those marshaled by critics of psychiatry. It was precisely our intention to give such philosophical issues a forum for debate and discussion. Neither do we wish to create (to use a popular post-modern term) an alien "Other," in the form of psychiatry's critics. On the contrary, as we state in our paper –citing the work of psychiatrist Laurence Kirmayer, "…not all critiques aimed at demonstrating the role of *cultural values* in psychiatric diagnosis are "anti-psychiatry"; nor do they necessarily originate from sources anyone would reasonably consider "anti-psychiatry" in his or her views." Moreover, we point out that while "...we have categorized antipsychiatry critiques as broadly divided into "foundational" and "antifoundational," it should not be surprising that "hybrid" arguments also abound." We offered our classification not with any implication that the foundational/antifoundational categories represent "essences" of any sort; but rather, that they might serve as a "heuristic model" that furthers understanding.

We agree with Dr. Lewis's admonition "…to take psychiatry's critics seriously" and "not to categorize our critics and dismiss them." Indeed, our goal was to analyze these critics critically—recognizing that their views may contain both errors and insights. For example, though we disagree with the post-modern, cultural reductionism represented in Foucault's thought, we agree with the need for attention to the cultural context of mental illnesses. Unfortunately, our current postmodernist spirit leads to too much imitation, and too little thoughtful criticism, of thinkers like Foucault. We hope that our paper may begin to change that trend, if only among our more philosophically-minded colleagues.

Reply to Elliott B. Martin, Jr., M.D.

While we appreciate Dr. Martin's diligent philological scrutiny of our paper, we wonder if he really intended to use the linguistic fragment, *Che sará*, with its incorrect accent marking; or if that was simply an oversight? Perhaps Dr. Martin had in mind the expression, *che sarà, sarà* , which is actually ungrammatical in modern standard Italian; the idea should be rendered "*Quel che sarà sarà*" or "*sarà quel che sarà*. But then, to paraphrase Churchill, grammatical corrections are something up with which one should not put! And so, having had a little fun with Dr. Martin, we now address some of the substantive points in his remarks.

Dr. Martin writes, "Szasz, by virtue of his defining mental illness in terms of its negation, implies that since mental illness is not a pathological phenomenon, then it must be 'something else'. In good old-fashioned postmodern terms, it must be an 'Other'….this plants Szasz firmly among the supposed 'Anti-Foundationalists', not the 'Foundationalists'. This then reduces the 'meta'-categories of anti-psychiatry proponents to one."

We would not agree that Szasz belongs among the anti-foundationalists, or that he believes "mental illness" must be "something else" in any *ontological* sense. Szasz's claim that "mental illness is a metaphor" does not stem from an anti-foundational or post-modern view that there are no "truths", that all narratives are merely assertions of power, etc. Rather, we believe Szasz wants to assimilate the term "mental illness" into the class of statements or expressions he views as *metaphors*; e.g., "The nation has a sick economy" or "Bigotry is a plague that has spread across the country." So Szasz wants to claim that the statement, "Joe has a mental illness" is in the same class of statements—and thus, has the same limited ontological "standing"--as the statement, "The U.S. has a sick economy."

We, of course, do not accept this Szaszian conflation of categories. In ordinary language, when someone says, "Joe has a mental illness," there is *no intention at all* of speaking metaphorically, nor is the locution ordinarily understood as a metaphor by most people. The statement is usually intended to mean, "Joe has a *real illness* that is affecting his ability to think or behave rationally." To be sure, we find the term "mental illness" problematic on other grounds (e.g., it raises various metaphysical problems concerning "mental" vs. physical conditions—a topic well beyond the scope of our discussion). But we stand by our position that Szasz's views are squarely within the logical positivist and "Virchovian" tradition (though Szasz may have misunderstood Virchow's views on what constitutes "disease"--see footnote on Virchow**, and Pies, 1979, op cit).

We confess some perplexity at our ex-philologist colleague's complaint that we "fail to engage in any meaningful dialectic between the past and the now"; and that by creating "novelty terms", we vitiate "any meaningful dialogue with the past." We attempted to place modern critiques of psychiatry (Szasz, Foucault et al) in a historical context precisely in order to engage in a "dialectic" between past and present philosophical thinking—hence, our discussion, albeit brief, of philosophers from Augustine to Ayer. Moreover, we would not regard our use of the key terms "foundational" and "foundationalism" as constituting "novelty terms" or neologisms. Specifically, our definition of "foundational" is compatible with (though not identical to) the long-standing definition of

"foundationalism" provided by the *Oxford Dictionary of Philosophy* (edited by S. Blackburn, 1994); i.e., as "the view in epistemology that knowledge must be regarded as a structure raised upon secure, certain foundations." Indeed, the philosopher Richard Rorty used the terms "foundationalism" and "anti-foundationalism" more than two decades ago, in his book, *Philosophy and Social Hope (1999).* Though he defined these terms somewhat differently than we do, we believe our usage is roughly compatible with that of Rorty.

Of course, the specific terms in our paper may or may not turn out to be helpful. Like Max Weber's ideal types, such constructs can bring out certain insights, at the cost of obscuring others. No concepts are absolute, and our "foundational/anti-foundational" terminology was intended only as a heuristic model—and all models have their limitations.

Finally, we would offer an observation on Dr. Martin's musing as to whether "…any of the steadfastly anti-psychiatry crowd, Dr. Szasz included, has ever been face-to-face with a floridly psychotic or manic individual, with an acutely suicidal or homicidal individual, with a catatonic individual." In the book, *Szasz Under Fire*, edited by Dr. Jeffrey A. Schaler, Szasz presents a brief autobiography. He comments that, although he "…had seen involuntary patients begging to be set free" in medical school, he specifically chose psychiatric residency at the University of Chicago because "…it offered no opportunity for contact with involuntary patients." (op cit, p. 19). He notes that the Chairman of the department, Dr. Henry Brosin, felt the Chicago program was "gravely deficient" in that the young Dr. Szasz would not have "…any experience with treating seriously ill patients" (in Brosin's words; op cit, p. 21). Szasz declined Brosin's recommendation to take his third residency year at Cook County Hospital, and notes, "I was not about to tell [Brosin] that the persons he called "seriously ill patients" I regarded as persons deprived of liberty by psychiatrists." (op cit, p. 21). We strongly recommend reading Dr. Szasz's autobiographical statement, as it clarifies many of his later philosophical positions.

Reply to Prof. Marilyn Nissim-Sabat

We appreciate the thoughtful comments from Prof. Nissim-Sabbat, and we agree that "relativism" is an important issue in this discussion, albeit not one we dealt with in any detail. We also agree that "…the nature and existence of facts is itself a very charged and profound philosophical question, one that engages ontology and epistemology, as well as ethics." However, in attempting a sort of anatomy of anti-psychiatry, we did not feel we could do justice to the complex issues of "relativism", ontology and epistemology to which Prof. Nissim-Sabbat refers. Moreover, we do not believe that the ontological and epistemological status of "facts"—controversial, to be sure-- is fundamentally different in psychiatry than in neurology, pain medicine, or several other medical disciplines. When, for example, a patient with migraine headaches tells a neurologist, "I see bright, jagged lines and feel nauseated each time I get pain in the left side of my head," the ontological and epistemological status of these linguistic and behavioral "facts" is not fundamentally different than when a patient tells a psychiatrist, "I hear threatening voices each time the aliens bombard my brain with microwaves." Nor is the currently-accepted diagnosis of migraine headaches--based almost entirely on symptomatic reports from the patient--fundamentally different than the diagnosis of schizophrenia, in the present DSM system. Similar claims could be made regarding the epistemological and ontological status of the "facts" doctors evaluate in various pain conditions, such as atypical facial pain. Of course, other medical specialties, such as orthopedics or infectious disease, do present somewhat different ontological and epistemological issues, vis-à-vis psychiatry.

Prof. Nissim-Sabat writes that, "…nowhere in their article do the authors indicate that they believe that psychiatry should seek a truth that is "absolute," nor do they discuss the problem of relativism. They do indeed believe that 'facts' are 'objective,' certainly in the sense that they are based on empirical observation allegedly unclouded by ideology."

We would like to aver that we do not believe that psychiatry or any other medical discipline is likely to arrive at any "absolute" truths. Neither do we assert that "objective" and "empirical" observations are necessarily always "unclouded by ideology"—or by theory. As one of us (SNG) has written, "…facts cannot be separated from theories…[and] no facts are observed without a preceding hypothesis…it is in this sense that philosophers say that facts are "theory laden"; between fact and theory no sharp line can be drawn." (Ghaemi, SN: A Clinician's Guide to Statistics and Epidemiology in Mental Health, Cambridge, 2009, p. 1). If, following Amartya Sen [Sen A: Objectivity and position. Lindley Lecture; Kansas, University of Kansas, 1992], we define "objective" endeavors as entailing (1) repeated, careful observations; and (2) achievement of good inter-rater agreement, we can still acknowledge that "objective" investigations may sometimes partake of "ideology". For example, , one can make careful measurements of skull size that are technically accurate and replicable by other observers, but do so under the influence of an "ideology" that asserts such measurements are closely related to intelligence or racial superiority. An objective measurement certainly *strives* to be free from bias, but we don't claim that this is always the case, or that all objective measures are veridical, "true", universally valid, etc. Our claim is simply that objective data are those derived from careful and repeated observation, and replicable by other competent observers—and that this description applies to many (though not all) clinical observations in psychiatry.

Prof Nissim-Sabat writes, "…The question arises then, if psychiatric values are based on judgment, are they not relative to, for example, culture or historical period? And, if they are relative, what motivates psychiatrists who are scientists to prefer one judgment to another, as to what, for example,

constitutes health?"

The question of what "motivates" psychiatrists to prefer some judgments to others is certainly important from a psychological and historical perspective, just as Thomas Kuhn felt that scientists' motivation has a great deal to do with how "paradigms" come to change in science. However, we believe that psychiatrists are, in principle, no more (and no less) influenced in their "values" than are many physicians in other specialties who treat other types of illness, such as obesity, chronic pain syndromes, or sexual dysfunction. All of these conditions partake of often implicit cultural values and value judgments that may shift over time and across ethno-cultural borders; e.g., the ideal or "normal" body weight or physique is greatly affected by time period and cultural biases. Similarly, what is considered "sexual dysfunction" also varies widely across time and culture. Indeed, as Jaspers put it (In Part 6, chapter 4, "The Concept of Health and Illness" (779-790)] the only feature common to any understanding of illness is the value judgment inherent in it.

As one of us (SNG) has noted, "[Jaspers'] perspective automatically negates the positivistic/Szaszian view that physical illness is a fact, while mental "illnesses" are cultural values. Just as in contemporary philosophy, the distinction between fact and value has been increasingly questioned, and in philosophy of science even destroyed, so in any rigorous understanding of medical illness, it would seem that value must be allowed a role." [Ghaem SN: On the Nature of Mental Disease: The Psychiatric Humanism of Karl Jaspers; Existenz Volume 3, No 2, Fall 2008]

Prof. Prof Nissim-Sabat, "Why are my or anyone else's judgments regarding what is good and bad with respect to health more worthy than anyone else's judgments?

Indeed, arguably, they are *not* more "worthy"; at least, there are no "experiments" or investigations *within the framework of science itself* that can demonstrate such a claim regarding "worthiness." Of course, one can try to link "value judgments" about health to putatively "objective" indicators, such as adaptive advantage or reproductive vigor; e.g., a body mass index of <25 is "better" than a higher BMI, because we can correlate higher BMIs with higher mortality rates, and hence, reduced reproductive potential. But this by itself can never prove that the value in question is more "valuable" than alternative or conflicting values; e.g., one might say, "But I value culinary pleasure more than longevity and reproductive capacity, and consider it a perfectly reasonable trade-off to lose a few years of life and eat whatever I want to eat!" Here, in our view, we are faced with something akin to Hume's admonition that we must avoid jumping from an "is" to an "ought".

Prof Nissim-Sabat writes: "… the authors discuss health as the fundamental value of psychiatry, but they do not ask whether or not the concept of health as such…can be relative… and therefore be devoid of universality." We believe that values regarding health are often *stable and enduring*, as well as *transcultural*—but this does not mean the values are either "absolute" or "universal." We believe that the concepts of "madness", "insanity", and "psychosis", for example, are relatively stable and cross-culturally acknowledged constructs that reflect widespread and enduring ideas about "health" and mental health.

Indeed, to our knowledge, virtually every culture ever investigated shares some variant of terms like "crazy", "*loco" "mishugah*", etc., though the particular expression of these states vary somewhat from culture to culture. That these conditions or states are "pathologized" transculturally reflects equally general and pervasive transcultural values regarding mental health; i.e., those who are "crazy", "mad", "loco", etc. depart from a state of good mental health in very characteristic and stereotypical ways. For example, the person who is "mad" is typically unable to realize his personal goals, seek and achieve her prudential interests (Dr. Robert Daly's term), maintain physical health, etc. But whereas these values are widely shared across time and geography, it would be an exaggeration to call them "universal" or "absolute". With respect to psychiatry, we believe values pertaining to "health" and "disease" are generally as well-founded as are analogous values (e.g., with respect to "normal" weight, normal pain tolerance, etc.) in several other medical disciplines.

Reply to James Phillips, M.D.

We appreciate Dr. Phillips' balanced and judicious assessment of our paper, and we agree with many of his comments. He asks, "…would it be fair to argue that the foundationalism debate is an affair of the modern era, with its origin perhaps in late medieval nominalism, its first dramatic expression in Descartes, and its flowering in reactions to 17th rationalism and the Enlightenment?_Dr. Phillips raises an interesting question in the history of philosophy. We suspect that some elements of the foundational/ antifoundational debate go back as far as ancient Greece, and may be seen in the arguments between Platonic idealists and Aristotelian empiricists, as well as in the radical skepticism of Sextus Empiricus ((c. 160-210 AD). (Sextus, for example, raised doubts about inductive reasoning long before David Hume). We agree with Dr. Phillips that the foundational/antifoundational distinction also has affinities with medieval debates between "realists" and "nominalists". And, of course, there were those in medieval times, like Pierre Abelard, who took somewhat ambivalent or intermediate positions in the controversy (see, e.g., Sharon Kay, *Medieval Philosophy*, 2008).

Similarly, we agree with Jim Phillips that in modern times, philosophers and philosophies do not divide neatly into "foundational" and "antifoundational" camps—a claim we do not make in our paper. Rather, we suggest only that the foundational/ antifoundational dichotomy is a useful "first cut" when considering the types of criticism that are usually leveled against psychiatry. Some phenomenologists, including Merleau-Ponty, may indeed incorporate both founda-

tional and antifoundational elements in their epistemology, as Dr. Phillips suggests. Similarly, we agree that many philosophers escape any simple "either/or" dichotomy that entails either a "no-holds-barred objective truth, or hopeless relativism in which all perspectives enjoy equal status." We are not experts on Hans Georg Gadamer, but we agree that Gadamer's hermeneutics and "merging of horizons" does not lend itself to a foundationalist/antifoundationalist dichotomy. As the Stanford Encyclopedia of Philosophy notes, for Gadamer, "…understanding is an ongoing process, rather than something that is ever completed, so he also rejects the idea that there is any final determinacy to understanding. It is on this basis that Gadamer argues against there being any method or technique for achieving understanding or arriving at truth." This might be construed as "anti-foundational" in our terms; however, it is not clear that Gadamer would endorse the postmodern view that "all perspectives enjoy equal status." There is, as we think Dr. Phillips would agree, a difference between saying that there is no "final" truth or understanding; and saying that truth and understanding are themselves *illusions*, or that one proposition is "as true as any other." We are prepared to accept a similarly complex view of Thomas Kuhn, whose views continue to be source of considerable controversy. Indeed, we would characterize our own epistemology as neither logical positivism, nor post-modernism. Rather, we endorse a version of "Enlightenment modernism" that sees knowledge as attainable, but provisional; and "truth" as shaped by one's frame of reference, but by no means illusory or "hopelessly relative." In our view, the world has become so relativistic that we prefer old fashioned words like "truth", even if used in small letters. Physicians, at least -- who kill people as well as save lives--cannot avoid being responsible for the truth or falsity of their life-and-death decisions.

One of us (SNG) also takes issue with Jim Phillips's comments regarding the claim that "…DSM III/IV diagnoses have failed the validity tests" and that this represents a failure of the modernist/positivist position. From several AAPP Bulletin discussions, it has become clear that the leadership of DSM-IV, at least, is clearly antifoundationalist-postmodernist, and believes that "pragmatism" is more important than data from scientific research--pragmatism being explicitly defined as whatever the leaders of DSM-IV felt are in the best interest of the profession and/or patients and/or others. Such purely utilitarian approaches to defining DSM-IV categories--peremptorily rejecting any objections as "naïve" realism--is akin to gerrymandering in political elections. There is no natural geography that explains the political map; similarly there are no biological "natural kinds" that could possibly match the *purposefully* (and this is is the important word) artificial definitions of DSM-IV; in short, DSM IV was *consciously* designed so that it would have to fail any modernist/positivist test. DSM III and IV failed precisely because of the antifoundationalist postmodernism that is behind them; these DSMs turned their back on and betrayed the Enlightenment modernist view of science and knowledge. One can hardly use the failures of such a postmodernist-relativist approach to psychiatric diagnosis -- about which failures we might all agree - -as a rationale to deny the modernist perspective.

Reply to Douglas Porter M.D.

We very much appreciate Dr. Porter's kind assessment of our paper, and find ourselves in broad agreement with nearly all of his points. We agree, for example, that "Foucault can be interpreted as joining ranks with Szasz in implying that evidence that psychiatric discourse is value-laden is tantamount to evidence of its illegitimacy." Indeed, as we have tried to show, the infusion of values into one's epistemology does not delegitimize one's epistemic claims—it merely introduces a note of humility and perspective, and discourages "reification" of one's categories . At the same time, we share Dr. Porter's concern that "…the power evinced by psychiatry is properly regarded as therapeutic as opposed to pathological." Our rebuttal of some critics of psychiatry certainly does not obviate the need to protect the rights and civil liberties—and of course, the basic human dignity—of those we treat.

Reply to Prof. Tim Thornton

We very much appreciate Prof. Thornton's thoughtful and detailed critique of our paper. He raises many important philosophical issues, only some of which we will address here.

Prof. Thornton writes, "I think that it is a mistake to hope that a binary opposition which locates forms of anti-psychiatry on both sides will, in itself, be very helpful. How could it? If a binary distinction exhausts logical possibilities – if everything is either in the one or the other category – then all the positions we can take will be in one or the other."

But as we noted above in reference to Dr. Phillips, we did not intend our foundational/anti-foundational dichotomy to exhaust all logical possibilities –merely to explicate *some* of the more important possibilities. Other typologies of "anti-psychiatry" certainly could have been discussed; e.g., the *Oxford Textbook of Philosophy and Psychiatry*—of which Tim Thornton is co-editor!--lists "five forms of antipsychiatry": *the psychological model; the labeling model; the hidden meaning models; the unconscious mind models; and the political control models* (pp. 16-17). (R.D. Laing is included within the "hidden meaning" models; i.e., "the apparently meaningless symptoms of someone with schizophrenia could be decoded, once their origins in the patient's contradictory experiences of others were recognized.").

Prof. Thornton writes, "I think it a mistake to aim a taxonomy at anti-psychiatry rather than at views of mental health and illness (or disease or disorder) in general. It will probably, at least, not be particularly helpful." We agree with Tim Thornton that – in addition to, not in place of, what we describe – the effort to define and understand the meaning of "health" and

"illness" is of immense importance in this discussion. But this expansive topic simply goes beyond the intent and purview of our paper.

Prof. Thornton writes: "The comment that Szasz' claim is 'far from a straightforward "analytic" claim; rather, it appears to be a *pseudo*-analytic' suggests that an analytic claim might be in perfectly good order. The problem is not so much that Szasz is appealing to the notion of an analytic truth; rather, he is doing that badly. If so, the problem with Szasz' anti-psychiatry is not that it is foundationalist but that it is bad foundationalism. But if that is the case, the taxonomy of anti-psychiatry into foundationalism and anti-foundationism does not seem to be carving the nature of anti-psychiatry at the right – significant, informative – joint."

On the one hand, we agree that Szasz's argument represents "bad foundationalism", and that, in principle, one might come up with a "good" foundationalist argument against psychiatry (though we have not seen one). But it would still be a *foundationalist* argument, which would probably fail for all the reasons we adduce against foundationalism in our paper. Furthermore, it seems to us that the category of foundationalism remains a useful "lens" through which we may examine both actual and potential arguments against psychiatry.

Prof. Thornton opines that "There is little point in aiming to taxonomise arguments against psychiatry, because whilst valid views in support of psychiatry are all alike; every unhappy anti-psychiatric argument is unhappy in its own way." We appreciate Prof. Thornton's paraphrase of Tolstoy ("Happy families are all alike; every unhappy family is unhappy in its own way") but we are not convinced that a taxonomy of anti-psychiatry is either pointless or fruitless.

Perhaps Tim Thornton might at least grant that, in our role as psychiatrists, we are exposed to a good many more of these anti-psychiatry arguments than is, say, the average philosopher. In our experience, most of these arguments typically *do* fall into one of the two major categories we have described—though, of course, there are many individuals unhappy with psychiatry for highly personalized or idiosyncratic reasons. Nor, once again, do we claim that our foundational/anti-foundational classification exhausts the universe of all complaints against, or critiques of, psychiatry. In the end, we shall have to see how our arguments "wear with time" and how useful those within and outside psychiatry find them.

**Endnote on Virchow and Szasz:

The pathologist Rudolf Virchow, of course, is best known for his maxim, *Es gibt keine allgemeine Krankheiten, es gibt nur locale Krankheiten.* "There is no general, only local, disease." However, in 1854, Virchow commented that one could localize "*diseases*," but "*not disease*." (See *Disease, Life, and Man: Selected Essays by Rudolf Virchow*, ed. By LJ Rather, Stanford University Press, 1958, p. 16).

The distinction is between *Krankheiten* [diseases] and *die Krankheit* [disease in general]. Furthermore, as L.J. Rather notes (in *A Commentary on the Medical Writings of Rudolf Virchow*, p. 56), Virchow "...rejects the claim that specific diseases are necessarily associated with specific anatomical lesions...and in addition, the claim that every disease at every stage of is development is open to anatomical study: 'Every anatomical change is a material one, but is every material change anatomical as well? Can it not be molecular?'"

Virchow hoped for the eventual "localization of *diseases*", but it is not clear that he believed *disease* per se was localizable. If this interpretation is correct, the "lesions" to which Szasz typically appeals would constitute the *basis* of disease, but not necessarily the *sine qua non* of disease. Here, an intriguing difference between Szasz and Virchow emerges. Szasz argues that: "Every 'ordinary' illness that persons have, cadavers also have. A cadaver may thus be said to "have" cancer, pneumonia, or myocardial infarction." (from Szasz T, *The Second Sin*, Routledge, 1974, p. 99).

Yet it would be passing strange, in ordinary discourse, to say that a cadaver is "ill" or "sick," except perhaps as a macabre joke! But if one would not seriously insist that a cadaver is "ill", how can a cadaver have "illness", as Szasz claims? Indeed, unlike Szasz,Virchow believed that *disease presupposes life*; thus, w*ith the death of the cell, the disease also terminates*. This is a crucial point. For Virchow, *when the organism dies, the disease terminates.* Now, it is a rudimentary principle of pathology (as Szasz's view makes clear) that *lesions* persist after the death of the organism. But if lesions persist and disease terminates, disease must be something over and above the presence of lesions, even at the molecular level. Indeed, one of us (RP) would contend that in ordinary discourse, *disease* usually entails *an enduring and substantial state of suffering and incapacity* in the living organism, and is recognized as such by ordinary persons-- long before it is classified as a particular *type* of disease by pathologists or other medical "experts." [see Pies R, Archives of General Psychiatry, Feb. 1979; and Kendell in *Szasz Under Fire*, op cit.]

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(President, continued from page 1)

Greta's situation? Is Greta's self-assessment any more (or less) subjective than the input from her family, friends, or therapist? If I grant Greta's evaluation of her own mental state, substance use, or safety status primacy, am I appropriately weighting the most important source of clinical information; or is my judgment clouded by loyalty to my patient, and my desire for her to live independently as she chooses? In psychiatry we seem to have the least and the most objective sources of information: from simple patient report to imaging and laboratory studies. My problem is that none of the information I have about Greta -- including collateral from people who know her well and the advantage of a longitudinal relationship with her – help me to know her, what ails her, or what she needs to maximize her health and safety. I can document extensively

that I don't know much, even with the most objective assessment a health care dollar can buy.

Claire Pouncey, M.D., Vice-President

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(Editor, continued from page 1)

way to analyze anti-psychiatry (Thornton), and whether it misses a more nuanced combination of these categories in much analysis and critique (Lewis, Phillips). The authors respond that their division is only one possible way to map out the anti-psychiatry terrain, that they do not intend it to be exclusive, definitive, or final, and that it is simply a division they have found useful. They indeed introduce some of the requested nuance in the target paper with statements such as: "Indeed, we should also be clear that not all critiques aimed at demonstrating the role of *cultural values* in psychiatric diagnosis are "anti-psychiatry."; nor do they necessarily originate from sources anyone would reasonably consider 'anti-psychiatry' in his or her views."

Jeff Bedrick challenges the thorny assumption—received wisdom since DSM-III and endorsed by the authors—that mental disorders are not different from other medical disorders. I am not sure the issue is settled in this discussion, or anywhere else, but I welcome the discussion. When the authors state in their argument that "'disease' is properly predicated of *persons* ('people')—not of minds, brains, bodies, tissues or organs," Bedrick questions, what about diseased plants, and the authors retort, what about cadavers? I would only add to this interesting exchange that I missed seeing Arthur Kleinman's distinction between illness and disease, which deserves a place in the discussion.

One of the themes threading its way through the target article and commentaries is the distinction between fact and value, with an assumption that psychiatric diagnoses represent some combination between neutral fact and non-neutral value. Marilyn Nissim-Sabet questions this assumption in arguing that, whatever may be the value status of facts, they are always theory-laden and thus not neutral. The authors agree and point out that Nassir Ghaemi has in fact written of the theory-laden aspect of supposedly objective facts. But they also try to nuance the discussion is arguing that carefully observed data have some claim on objectivity.

Finally we should note a bit of levity in this appropriately sober symposium.. Our linguistically trained commentator, Elliott Martin, calls the authors out on their use of the verb "entitle" when they mean "to title." The authors politely return the grammatical favor, hoisting Martin on his own petard in noting that his *Che sará* flubs both the Italian accent (Que *sarà)* as well as the phrase (*Che sarà, sarà).* As a self-avowed pedant, I enjoyed the exchange.

JP

The Association for the Advancement of Philosophy and Psychiatry was established in 1989 to promote cross-disciplinary research in the philosophical aspects of psychiatry, and to support educational initiatives and graduate training programs.

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