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From the Editor

Saving our Minds

Let me first express my gratitude to Robert Daly and his commentators for a vigorous exchange over issues that challenge all of us. We leave this discussion better informed than ever in the assertion of psychiatry as a medical discipline and in the distinction between psychiatry neurology

The discussion broke somewhat into the practical and the theoretical: what psychiatrists do, and what is the theoretical foundation of that work. In both dimensions of the discussion I noted a caution in the use of words such as 'mind' and 'mental' - especially the first. It's as if we are all so beholden to neuroscience that talk of 'mind' smacks too much of immaterial soul stuff.

Can we justify talk of mind? Does it have a place in our neuroscientifically oriented specialty. I invite you to listen to Nancy Andreasen, nobody's idea of a neuroscience softy. In an editorial titled "What is Psychiatry" she writes:

> So what is psychiatry?
> Psychiatry is the medical specialty that studies and treats a variety of disorders that affect the mind—mental illnesses. Because our minds create our humanity and our sense of self, our specialty cares for illnesses that affect the core of our existence. The common theme that unites all mental illnesses is that they are expressed in signs and symptoms that reflect the activity of mind—memory, mood and emotion, fear and anxiety, sensory perception, attention, impulse control, pleasure, appetitive drives, willed actions, executive functions, ability to think in representations, language, creativity and imagination, consciousness, introspection, and a host of other mental activities. Our science explores the mechanisms of these activities of the mind and the way their disruption leads to mental illnesses.

And she continues later in the editorial:

> If psychiatry deals with diseases of the mind, does it also deal with diseases of the brain? Unequivocally, yes. What we call "mind" is the expression of the activity of the brain. "Mind" is our abstract term that refers to mental functions such as memory or mood, while "brain" is the neural assembly of molecules, cells, and circuits that produce those functions….We are physicians to both the mind and the brain. We modulate the psyche with psychotherapies that address mind mechanisms such as memory or consciousness, but this modulation works at the neural level by producing changes in the brain. We also modulate the psyche by prescribing medications that work directly at the neural level, but we see their effects at the level of mind as we observe a depression lifting or hallucinations diminishing. (*Am J Psychiatry* 154; 5, 1997).

If we follow Andreasen's train of thought, might we say, however crudely and

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President's Column

This weekend I accompanied my 18-year-old niece to the college where she will matriculate this fall. I am reminded of the similar visit I made when I chose my university exactly 30 years ago. Both were formal recruitment programs for prospective students. I, like my niece, was bursting with excitement to launch my personal and academic lives; and to meet the people who would become my friends, teachers, and colleagues. At 18, unlike my niece, I had no idea what I wanted to study, or how far I wanted my scholarship to take me. I did not have a strong sense of my aptitudes or my preferences.

That one day in 1983 was serendipitous. I don't remember many of the details of the formal program. What I do remember is a reception for prospective matriculants to ask questions of current students, each of whom wore a name tag with the name of her department of concentration. One sophomore was wearing a badge declaring his major in Biomedical Ethics. "What's that?" was my erudite question. His response: "It's kind of a combination of philosophy and medicine. You talk about ethical questions that come up in different medical situations." That was it. "I'm going to study that, too." And so I bumbled into the world of interdisciplinary study.

I did concentrate my college studies in Biomedical Ethics, although friends at the time teased that it would prepare me for nothing but "pub talk." I tried to make sense of the world through different disciplinary lenses, not always a straightforward project. I actually found a job after college that allowed me to use and develop what I had learned, which at the time seemed fortuitous, and now seems miraculous. What I realized over the years is that it all my questions come back to philosophy. I wanted to ask better questions, perhaps even answer them. As I went on, I realized that what compelled me about medical ethics was how epistemology and ethics challenge and reinforce each other – what we know influences what we endorse, and what we do or don't sanction shapes what we can know. Eventually, my interdisciplinary pursuits led me to philosophy of psychiatry, the very interdisciplinary field I now call my intellectual home.

So here I am, 30 years later, following the path I stumbled onto completely accidentally. I still think interdisciplinary work sounds cool on a name tag, and I know it makes good pub talk. Interdisciplinary work is fascinating and topical, challenging and difficult, and I continue to believe it fuels important new ways of

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'Sanity' and the Origins of Psychiatry

Robert W. Daly, M.D.

(The author thanks Paul Archambault, Ph.D., Elizabeth McCarthy Daly, M.A., James Dwyer, Ph.D., C. V. Haldipur, M.D., James Phillips, M.D., Ronald Pies, M.D., Paul Prescott, Ph.D., and Kendra E. Winkelstein, J.D. for their comments and suggestions regarding this paper.)

Summary

The American Psychiatric Association has now promulgated a revision of its diagnostic and statistical manual (DSM-5). The states of affairs classified are those occasions on which some person is judged by himself and/or others to be 'mentally disordered' or 'mad.' For those engaged in classifying these disorders, the initial problem involves specification of a principle of discernment in terms of which candidates for classes and for classification are identified. Subsequently, rules based on similarities and differences, are developed for assigning particular cases to a class of disorders, e.g., "Mr. Jones has schizophrenia." This response to the revision concerns the initial problem - the principle of discernment in terms of which candidates for classes and for classification are identified.

DSM-5 says only the following regarding the judgment that a person is "mentally disordered:"

> A mental disorder is a syndrome characterized by clinically significant disturbance in the individual's cognition, emotion regulation, or behavior that reflects a dysfunction the psychological, biological, or developmental processes underlying mental function. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. (American Psychiatric Association, 2013, p. 20)

Is it possible to offer a more conceptually elaborate and useful account of the judgment that a person is mentally disordered?" I believe so.

One school of thought depicts persons judged to be mentally disordered as suffering from diseases of the brain. States of madness should therefore be discerned and classified in keeping with knowledge of how the brain, as an element of the nervous system, functions in health and ill-health, and in keeping with the utility of this principle for the practice of medicine in treating and preventing such states. By implication, the practical aim of psychiatry, is to restore and/or maintain the normal functioning of the brain. In terms of medical specialization, psychiatry is, therefore, awaiting the discovery that it is, properly, neurology.

This approach may be adequate for classifying a subset of conditions prominently manifested in behavior and experience such as disorders due to a general medical condition, diseases of the brain, toxins and drugs, and certain developmental and cognitive disorders.

But this principle for identifying all states of madness is inadequate for several reasons. It fails to accurately portray the full range of conditions exhibited and experienced by persons who are judged to be mad. It assigns too much of clinical psychiatry as a specialty of medicine to neurology's waiting room. And it fails to generate useful conceptual and practical guidance for the care of persons who seek aid from psychiatrists.

In this paper I offer a rationale for an alternative starting point for characterizing persons judged to be mentally ill and in need of psychiatric services. This principle is less sharply focused and less vivid than "mental disease is brain disease," but I believe, more comprehensive with respect to the range of untoward conditions designated as 'mental disorders'; it grounds psychiatry as a medical specialty; and, is more useful, overall, in according intelligibility to the practice of clinical psychiatry.

I argue that the conditions to which the psychiatrist attends are best portrayed as diminutions of 'sanity' – that form of human health a person enjoys when the elements of his personality are well enough founded, organized, developed, and integrated with one another, and with his knowledge and capacity to choose, so that a person is able, by means of his actions, to secure his prudential interests. Following an exposition of the basic tenets of neurology, I analyze the features of the practical lay judgment that someone is mad, and show that the psychiatric examination, and in particular, the use of the mental status examination presupposes tacit criteria for sanity - the principle of discernment used for identifying problems of health as mental disorders. In addition, this analysis of intended to specify and relate ideas essential to the conceptual origins of psychiatry as a medical specialty. *

Part One: Initial Considerations

Psychiatric Disorders Are Diseases of the Brain

In recent years, citing or anticipating advances in the neurosciences, a variety of authors (e.g., Baker and Menken (2001), Insel and Quiron (2005), Martin (2002), Murphy (2006), Ramachandran (2003), Reynolds et al. (2009)), assert or imply that psychiatric disorders, or at least "authentic" psychiatric disorders, are diseases of the brain. Because neurology is that branch of medicine that diagnoses and treats diseases of the brain and peripheral nerves, proponents of this view suggest that psychiatry is or should be re-constituted as neurology or a subspecialty of neurology. The disciplines of neurology and psychiatry should now

*Throughout this text, I use the idea of 'sanity' to understand such terms as 'mental disorder,' 'mad,' 'crazy,' 'psychiatric disorder.' I write in this way for two reasons. There is, in English, no single set of terms that have the lexical and historical stability, elegance, coherence, specificity, and rich set of denotative meanings that refer to the states of persons to which psychiatrists minister. The second reason is this: I want the reader to consider the coherence and utility of the conceptual apparatus argued for in the paper.

be merged (Martin 2002); psychiatrists need to become educated as "clinical neuroscientists" (Insel and Quiron, p. 2223); academic and clinical psychiatric units should become elements of neurological institutes (Tesar 2006); and, in colleges of medicine, "the clerkship in psychiatry should be merged with the clerkship in neurology so that students will have more time for electives." (Haldipur 2010)

In addition to those in academic medicine, others in the United States are now disposed to view psychiatric disorders as diseases of the brain. This belief is encouraged and supported, knowingly or unknowingly, by the collective payers for health care (i.e., private corporations, governments, and insurance companies), by pharmaceutical corporations, by research establishments, by voluntary associations, and by many professional "therapists" engaged in market competition with psychiatrists who include psychotherapy as a form of treatment for their patients.

Given the assertions of the professionals noted above - together with recognition of the commercial, governmental, and other forces at play - and the fact that the American Psychiatric Association has again revised its Diagnostic and Statistical Manual, it is appropriate to re-consider anew the conceptual foundations of psychiatry as a medical specialty. Our path of reflection will initially engage the assertion that because mental disorders are diseases of the brain, psychiatry, as a medical specialty is, or should be a branch of neurology. Are there, upon reflection, good reasons for promoting this change in the division of labor within American medicine?

If there are sound, practical, *medical* reasons why we should affirm that psychiatric disorders are diseases of the brain, it is reasonable to assert that psychiatry is neurology. We should then reform our practices, designations, disciplines, modes of clinical organization, and educational endeavors. Psychiatrists should become neurologists or clinical neuroscientists or psychoneurologists. The disciplines of neurology and psychiatry should be merged and departments of psychiatry become elements of neurological institutes. Colleges of medicine should merge clerkships in psychiatry with those in neurology. We should also have one professional organization and one set of lobbyists.

The Nature of the Question

I will pursue the idea that psychiatry is neurology as if it were simply up to us, as clinical psychiatrists, to explain why psychiatry, in the light of advances in the neurosciences, should or should not be recognized and reorganized as neurology.

To address the assertion that psychiatry is neurology requires that we re- examine the clinical origins and conceptual coherence of psychiatry as a specialty within the institution of clinical medicine. Understanding the social origins and conceptual foundations of psychiatry will not tell us how psychiatric disorders should be classified, or about the best treatment for a certain patient, or about why some people develop a particular kind of psychiatric disorder. But our investigation should provide good reasons why it is legitimate to be concerned with these matters, topics that presuppose we know the meaning of asking them within the context of "the practice of medicine" in the West. This inquiry is concerned with the reasons for identifying and naming certain forms of human disordering as "a psychiatric condition" or "a neurological condition" in the first place.

Health, Ill-health, and Medicine

As the path of our reflections is funded by terms associated with the philosophy of medicine, we must say a few words about these terms.

Health, here considered as the organismic capacity of a human person for "having a life" (including the organismic capacity for relations with other persons) is a good in itself, as well as a prerequisite for the securing of other goods. It is among the goods that are generally requisite for human flourishing. In the most primitive sense, we know that a person is healthy enough when he enjoys the organismic capacity to secure his

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May 3 & 4
New York, NY
Sheraton Times Square Hotel
(Conference L, Lower Lobby
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(in conjunction with the American Psychiatric Association Annual Meeting Conference)

Edwin R. Wallace IV Lectureship in the Philosophy of Psychiatry

Moderator
John Z. Sadler, M.D.

Speakers
Osborne P. Wiggins, Ph.D.
Professor Emeritus,
Department of Philosophy
University of Louisville
Louisville, KY

Michael A. Schwartz, M.D.
Clinical Professor & Regional Chair of Medical Humanities, Texas A&M University Health Center
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Title
Clinical Reasoning as Knowledge and Therapy

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prudential interests in the course of living his life.

Ill health diminishes or threatens to diminish that organismic capacity and takes many forms, e.g., injury, sickness, malnutrition, pain, deformation, degeneration, and, madness.

In the clearest cases, ill-health is identified and summons clinical attention when a person's capacity is diminished enough to imperil his organismic ability to secure his "prudential interests": e.g., remaining alive; avoiding death, serious disease, injury, and pain; securing his personal safety and the safety of his possessions and community from the violence of persons within and without the community and from natural hazards; and obtaining, by way of communication with others, the minimal satisfaction of desires common to human beings. The states of persons commonly said to be "mentally ill" are no less problems of health than are illnesses, injuries, deformations, pain, and malnutrition. All of these states (or conditions) may constitute a diminution of the organismic foundations of a person's capacity for action and forbearance.

Health and ill-health are therefore basic concerns of all peoples in every time and clime. The institution of medicine, in its various manifestations (clinical care, public health, research, education, etc.), arises from and expresses, however imperfectly, the intention to maintain or restore the health of persons (Kass 1981).

Given the many types of ill-health and the diverse skills required to minister to those in ill-health, it is not surprising to find a *division of labor* among the ranks of physicians and among the other occupational classes that populate this institution. Clinical specialties are created, sustained, and abolished because we deem such divisions to be socially useful for everyone or for some segment of society--not simply because they are useful for physicians.

As divisions of medical labor, specialties arise and disappear in course of history in complex ways. At present, specialties are organized in response to a variety of considerations: our knowledge of human biology; new kinds of knowledge pertinent to securing human health (e.g., clinical genetics); new techniques that require new types of practical skill (e.g., interventional radiology); the identification of types of disorders (e.g., infectious diseases), or disorders of various organ systems (e.g., nephrology), or of various regions of the body (e.g., otolaryngology); health and ill-health at a particular stage of the life cycle (e.g., pediatrics); how care is funded and organized (e.g., emergency medicine); and special milieus (e.g., aerospace medicine).

While most physicians might subscribe to a general notion of 'health' as robust human organismic flourishing, these examples of specialties remind us that specialization is achieved by focusing and limiting attention to the acquisition and refinement of certain practical skills according to some principle(s). As a corollary, each specialist understands 'health' somewhat differently, not only in each case, but also in accord with the kind of good health, or component of health, the practitioner seeks to promote. The sense of 'health' to which the patient with a broken leg has been restored with the aid of the orthopedic surgeon is somewhat different from the sense of health to which the patient with pneumonia has been restored by the aid of the internist. In practice, specialists do not espouse a univocal sense of 'health.'

The histories of psychiatry and neurology as specialties of medicine are linked. Neuro-psychiatrists and behavioral neurologists have similar interests and views. Psychiatrists and neurologists have a common interest in the health of individuals to whom they both attend. But, I shall argue that neurology and psychiatry are, for the most part, now constituted by means of different principles of human organismic ordering and disordering. These two specialties therefore exhibit different practical aims, requiring the acquisition and competent exercise of different practical skills. Because of these different practical aims, the discipline of each specialty proceeds from a distinctive body of theoretical knowledge, composes that knowledge in different ways, and speaks the generic vocabulary of medicine in a different voice.

Part Two

"The physician has a tendency to forget that it is the patients who call him." (Canguilhem 1991, p. 208)

In this phase of inquiry, we identify and compare both the general features of the complaints, claims, and associated marks of disordering generated and revealed by the persons who seek the aid of neurologists and psychiatrists, and the concepts that animate the generic responses of the two specialties to those complaints. In short, we compare some of the ideal-typical features of each specialty. This discussion will enable us to distinguish the aims of these two specialties. We will begin with neurology because we need to know what neurology is if that is what psychiatry is to be – and also because it is easier to describe.

Neurology and Psychiatry as Specialties of Medicine

As physicians, neurologists and psychiatrists have, or should have, something in common - a commitment to act in a regular and practical way to maintain or restore the health of persons. We should also recognize that, as physicians, neither neurologists nor psychiatrists originate their own work. Persons in search of aid for what *they* perceive and judge to be problems of health originate the work of both. There are neurologists because there are persons who are not healthy in a certain way and are incapacitated, and suffering. There are psychiatrists because there are persons who are not healthy, are suffering, and are incapacitated in another way.

Neurologists and psychiatrists share an interest, though a different interest, in the behavioral and experiential foundations of the organismic capacity for action and forbearance, and in the various diminutions of that condition we name 'ill-health.' In the proto-patient's search for aid, both are also concerned with the marks of delirium, dementia, cognitive deficits, mem-

ory impairments, sexual dysfunctions, developmental defects and disabilities, pain, and abnormal movements.

But the marks of these disorders are typically attended to in different ways by the neurologist and the psychiatrist – even when they consult about the health of the same patient. For example, a conversation between a neurologist and a psychiatrist about the clinical significance of a patient's aberrant movements reflects their common concern as physicians for the health of the patient. As I aim to show, it will also reveal their knowledge and experience of two sets of practices and two related but distinctive cultures for understanding and responding to ill-health. Let us examine those differences.

About Neurology

In addition to the complaints, signs, and symptoms of the disorders noted above, other marks of ill-health that summon the neurologist include confusion, syncope, vertigo, seizures, stupor, coma, aphasia, ataxia, agnosia, tremors, disordered speech, and certain alterations of the "five senses."

Judgments that these behavioral and experiential manifestations of diminutions of the capacity to act and forbear are the province of the neurologist (or neurosurgeon) turn, in the clearest cases, on knowing that such clinical signs and symptoms are regularly correlated with typical alterations of the tissues, cells, or sub-cellular components of the nervous system. In principle, if the clinical marks of a neurological disorder are present, a typical alteration of structure and function of the nervous system is found. If the typical structural alterations are present, the clinical marks of the disorder appear, sooner or later .

The altered structures of the nervous system are also correlated with (or sustain a search for) typical patho-physiologies that arise from or produce altered structures. Altered local or diffuse structures that are to varying degrees associated patho-physiologies also "account for" or "explain" the clinically manifest changes in the behavior and experience of the patient, changes that have common and recurring features that allow these states to be recognized, classified, and understood to be dys-functions of the central and/or peripheral nervous system.

Some clinical marks of ill-health are *in fact* correlated with discernable changes in the anatomy and physiology of the nervous system, changes that *in fact* are at variance from the anatomical and physiological norms and ideals that underwrite the normal or desirable functioning of the human brain and nerves with respect to movement, range and occasion of emotional experience, memory, thought, language, sensation, etc., insofar as such functions depend on the integrity of the nervous system. The typical disabling conditions that fit this pattern are known as "insults to the nervous system": insults such as traumas, vascular abnormalities, infections, tumors, toxicities, demyelinating diseases, nutritional deficiencies, deformations, degenerations, metabolic errors, encephalitides, and genetic impairments of the structural/ functional development of the brain, spinal cord, and peripheral nerves.

Judging and knowing that someone has a neurological disorder typically requires an explicit or implicit reference to the demonstrable changes in an organ system - manifest changes in "the stuff" of which the brains and nerves of human beings are composed. Just as these alterations of the nervous system deviate from the ideal or statistically typical biological norms for those structures (that is, from the ideals and norms for structures associated with "normal functioning" or "functional integrity" of the nervous system), so too does the untoward behavior and experience of the patient deviate from what that person should normally experience and be able to do and to be if his capacity for action and forbearance were "normal" or organismically healthy.

In sum, clinical neurology is concerned with the identification, diagnosis, medical (versus surgical) treatment, and prevention of conditions of ill-health known or credibly believed to be manifestations of changes in the nervous system of human beings. This is what is signified by the alterations in human behavior and experience and associated organismic diminutions in agential capacity to which the neurologist *qua* neurologist attends and responds. In cases correctly understood in this way, the practical skills and disciplines of the neurologist (or neurosurgeon) are, for good reasons, deemed relevant for diagnosis and treatment.

Because neurology is a specialty concerned with the ordering and disordering of an organ system – the nervous system – the literature of the discipline of neurology is filled with findings drawn from knowledge of the clinical craft of the neurologist and findings of the neurosciences that have or might have implications for the practice of neurology. In the same sense, textbooks and journals of nephrology are filled with the findings of the craft of nephrology and of the renal-sciences and their implications for the practice of nephrology.

No one doubts that the normal functioning of the nervous system is required for the pursuit by the patient of his prudential interests and for his efforts to lead a life. *The possibility of all of our experiences and activities – whether healthy or unhealthy - requires that they be underwritten by the nervous system as well as other biological systems and processes that in their way constitute a human person.* But note that it is not usually necessary to refer to sanity or madness (or to any other "registers" or modes of meaning) when judging that a person has a neurological disorder. Indeed, many patients with neurological disorders are sane. If reference is made to madness in the diagnosis of these states, such states, for the reasons given above, are considered to be manifestations of diseases of the nervous system.

About Psychiatry

Psychiatrists do not originate psychiatry. Patients do not seek aid in order that there be psychiatry. On the contrary. Even if psychiatrists are responsible to some extent for the culture of complaint and claim elaborated by the members of society, psychiatry originates from states of affairs that constitute the lives and

cultures of the persons who are diminished, suffering, and seeking aid.

Set aside for the moment, various ideals, hopes, desires, and dissatisfactions concerning psychiatry. Instead, reflect on the voices of those who enter our waiting rooms, emergency facilities, and in-patient units. Why do people seek the services of psychiatrists? What do they tell psychiatrists about what is the matter with them and what it is that they want in the "pre-patient phase" that could help us to decide whether psychiatry is neurology?

By reflecting on the themes common to the stories patients initially tell, as well as on the associated experiences and the behavior they report and exhibit, can we detect and depict the generic features of their initial claims, complaints, and marks of disordering that they and their intimates have discerned? If that is possible, we can identify and understand some of the general features of the judgment *that* someone is mad, (i.e., the way in which different states of madness resemble one another) without appealing to the culture of psychiatry - for that is what is in question. We want to know this: what is common to persons to whom madness is attributed in a medical sense? How does such a person differ from his or her "normal condition" and from others who are not deemed mad?

We address these questions by engaging in two studies. In the first we seek to identify the common implications of the complaints and stories of those who seek the aid of psychiatrists. In the second study, the results of the first study serve as a prologue to a reflection on what is conceptually required for the psychiatric examination (in particular the mental status exam) to make sense. These studies serve to illuminate the aim of clinical psychiatry and the principles involved in its practice.

The First Diagnosis

It is not the psychiatrist who makes "the first diagnosis." It is usually the prospective patient and/or others who judge in their everyday language *that* someone has changed and is "not himself," "deranged," "not right," "mentally ill," and in need of aid. These judgments, made prior to consultation with the psychiatrist, provide the reasons and motives for seeking aid from the practitioners of this specialty. What are the common and characteristic features of these judgments that are regarded as credible?

Five Features of the Judgment That Someone is Mad

i. A story of diminished capacity to secure prudential interests.

ii. A story in which conduct, relative to securing one's prudential interests, is replaced to some extent by mere behavior; intelligible experiences of self and others are replaced by un-intelligible experiences. Instead of his authoring activities as he desires or is expected to do, the person's activities are determined in some other way.

The story, as a condition of its possibility, requires tacit knowledge of the norms for acceptable conduct and of norms pertaining to the capacity to enact those activities.

iii. Manifest 'marks of madness.'

iv. A belief that a person, considered as a particular agent, is not rightly or normally ordered. He or she is organismically disordered.

v. Affective distress: e.g. bewilderment, anxiety, confusion, a sense of enigma, perplexity, conflict, ambiguity.

i. The person seeking aid (and/ or his intimates) generates and communicates a story in which he is persistently unable, in some or many ways, to use his knowledge to conduct relations with others and his environment that enable him to live his life - perhaps even to stay alive. As noted above, this narrative indicates that a person does not have (or fears will soon not have) the capacity to author his or her activities in some or many contexts, to avoid death, disease, injury, and pain; or to secure the safety of his person, possessions, and community; or to achieve, at least in some minimal way, the gratification of his human desires and the avoidance of evils, both moral and natural, that could befall him.

In clear and credible cases, his story reveals that something untoward and enduring has (or has failed to) come about relative to his powers of action or forbearance, now making it impossible or very difficult for him to secure some or many of his prudential interests. In many cases, though not all, this incapacity and its consequences, are important enough to move someone with the social power to do so to seek the attention of physicians.

ii. In stories of madness, conduct in relation to others is replaced to some extent by mere behavior; intelligible experiences of self and others are replaced by un-intelligible experiences of self and others. *Instead of authoring his or her activities in situations in which the person desires or is expected to do so, the person's activities are determined in some other way.* Given the untoward nature of this state, this feature of the judgment engenders an impersonal or objective attitude toward the phenomena (not the person) in question and inaugurates an inquiry into *why* the state has come about including consideration of how that person and others have conducted themselves in the past.

Here, however, we emphasize another aspect of this second feature. As noted, the judgment that a person is mad implies *a contrast* between what a person should be capable of doing and being in his or her circumstances, and what he or she is now, and in a continuing way, incapable of doing. The judgment therefore presumes and requires knowledge, characteristically tacit knowledge, applicable to the person in question, of many and variable sets of *norms for performances* in various settings and relationships – and, further, to *norms pertaining to the capacity to perform them*. Knowledge of the advent and presence of madness depends upon understanding what a particular person desires and expects to do and to be (and/or what others desire

and expect) when he or she is not mad, that is, when his affective states and reflective consciousness are integrated with his knowledge and capacity to choose what to do to secure his prudential interests. It is relative to these norms, and by way of contrast, that the judgment *that* a person is mad is reached. *The "first diagnosis" is not made relative to the norms and findings regarding a person's brain or any of the other stuff of which persons are composed, nor of a state with a merely psychological or 'mental' designation.* Madness is predicated of persons as agents.

iii. The third feature of a credible judgment is a reference to a set of manifest *marks of madness* that have taken the place of the proto-patient's agential powers and that are interpreted as signs or evidence of his disability. In the first instance, those who summon the psychiatrist identify these marks.

As is well known, the range of such marks is considerable. They include false beliefs, seeing things and hearing voices that are "not there," forgetting, disorientation, exotic and apparently groundless suspicions, altered states of emotion, speech that cannot be understood, racing thoughts, confusion about states of affairs and about what to do next. Other marks are a lack of ability to attend to, comprehend and judge how to respond coherently to current circumstances; bizarre or unintelligible activity that disrupts and confounds those who have knowledge of it; experiencing of one's self and the world as "unreal"; hopelessness, helplessness, and hyperactivity. Other signs and symptoms include grandiosity, immobility, diminished capacity to initiate action or to not do something (addictions), sleeplessness, sleeping most of the time, fatigue and inability to concentrate, enduring feelings of profound worthlessness, panic, anxiety, and reports of phobias, and obsessions.

iv. The advent of some set of marks of this sort associated with a diminished or inadequate capacity for action in the social-cultural context of a life in progress grounds "the first diagnosis," engenders suffering, and motivates the quest for aid. In this state of affairs, a fourth feature of the judgment is revealed – a belief that the proto-patient, as a human agent, is not only differently ordered, but also not rightly or normally ordered, i.e., disordered in an undesirable way. He is not constituted with respect to his or her ability to author some or many actions in the way that he or she was or "used to be," and/or in the ways that other persons, as agents, are. This conviction can be affirmed even when this person continues to be able to perform many or even most activities satisfactorily or even well. Most people who are mad are not merely mad. As a corollary, and with notable exceptions (e.g., intoxication with alcohol and other substances), this disordering and the attendant disabilities are not usually understood by those seeking aid to be the immediate result of actions intended to bring the disorder about.

As noted elsewhere, judging that someone is mad points to a problem with the capacity *for* action, not to problems about how best to use or exercise that power. It does not apply to the sorts of suffering ordinarily expected in the course of living a life, e.g., the ups and downs of life, frustrations in securing one's interests, satisfying one's desires, or avoiding evils. It does point to a problem with the equipment required for action and forbearance. Problems with the equipment necessary for playing a game are not the problems intrinsic to the game.

v. Persons making the first diagnosis often do not know why this distressing state has come about or what is to be done to improve this state of affairs. The fifth component of the judgment is affective as well as cognitive: bewilderment, anxiety, confusion, a sense of enigma, terror, perplexity, conflict, and ambiguity are common and important features of the ordinary judgment that someone is mad. This is especially true in the many cases in which a person's activities and experience simultaneously display conflicting signs of the integration and of the disintegration of the elements of personality - with each other, and relative to agential expectations. As a result, it can be very difficult in the pre-patient phase (as well as in the clinic) to know whether even the same components of a person's experience and behavior should be perceived as evidence of a disorder or ascribed to the activities of that person that are experienced or authored by him as a human agent.

Summary Reflections

The lay judgment that someone is mad or mentally ill has these features before the psychiatrist is consulted. Such lay judgments are made in every time and clime but only regarding human beings of whom agential performances are expected. Indeed, there is no way to arrive at the judgment that someone is mentally ill absent operative norms for performances and for the capacity of a person, understood as a particular human agent, to enact them. 'Health,' as the organismic capacity to have a life (minimally, to be alive), includes the capacity to lead that life, to author activities that enable a person to secure his prudential interests. States of madness, like neurological disorders, are generally known and for good reasons to be problems of ill-health. It is not surprising that persons in such states may bring themselves or be brought to the attention of physicians.

In keeping with what has been said about the organismic capacity for agency and action, the judgment *that* a person is 'mad' is not made by either the laity or by physicians regarding certain sorts of human beings: namely fetuses, persistently unconscious persons, and, in the modern world, persons who are profoundly "mentally subnormal" – human beings of whom agential performances are not expected - though *all* these kinds of people may have neurological disorders. Any kind of human being, whether capable of authoring his conduct or not, can be diagnosed with a neurological condition.

The judgment that someone is mad is practical. It concerns what is to be done given that a person is, to some extent, organismically disordered and

disabled in the way we have described in the contexts of his life circumstances and relative to what is expected of him or her as a person leading a life in those contexts.

The five features of this practical judgment now permit us to distinguish it from other judgments with which it is sometimes confused or conflated.

Though the judgment that someone is mad necessarily entails references to the behavior and experiences of a person, this judgment does not pertain to behavior or experience *per se*. It does not, in the first or last instance, indicate that a person has a "behavior disorder" or an "emotional disorder." Nor does it call attention to a deficit or lack of a particular "function," e.g., of memory, perception, cognition, or language, as these functions are understood in neurology. It does not announce a vice or a moral judgment about "traits of character" informing us as to whether this is a good or bad person, or whether someone has performed a noble or base act, nor does it identify a political or religious point of view or stance with which we disagree. Nor does this judgment pertain simply to the legality of conduct. Nor is it an aesthetic judgment that tells us whether a person's activities are beautiful or ugly, or a technical judgment that tells us whether someone is effective or efficient with regard to achieving a particular aim. It is not simply a judgment about a lack of knowledge, i.e., ignorance, or about an erroneous judgment regarding the truth or falsity of a proposition, or about the rationality of someone's claims or activities relative to an impersonal standard of rationality, or about fitness for a particular activity. Neither is it correctly applied to traits of personality (e.g. shyness), to transient states of exultation or grief, nor to the great variety of ways in which people experience unhappiness, even tragedies, associated with the vicissitudes and misfortunes of having a life.

Finally, the features we have so far identified of the judgment that someone is mad could, at least provisionally and in some cases, be assigned to someone who proves to have a neurological disorder. So, on the basis of investigating the common features of these states expressed or implied by the complaints, stories, and behavior brought to the attention of physicians, we have not yet clearly distinguished neurological from psychiatric conditions.

Enter Psychiatry

Keeping before us what we have learned about credible lay judgments that someone is mad, we now consult knowledge bequeathed to us by the practice of psychiatry and traditions of reflection and language that arise from and refer to this practice. This phase of inquiry is internal to medicine and concerns the grounds on which we may further distinguish between states of ill-health that are neurological conditions and those that are the province of the psychiatrist.

We have noted the great range of complaints, stories, and 'marks of madness' that are brought to the psychiatrist. Psychiatrists name these marks as "signs and symptoms" in keeping with the generic language of medicine. While every patient is different, even crucially different, from other patients, in a rough way the same kinds of marks are common to many subsets of different patients. These observations, as is well-known, serve as a basis for *classifying* the kinds of disorders exhibited by persons identified as "crazy": for example, psychoses, mood disorders, anxiety disorders, eating disorders, substance-related disorders, identity disorders, adjustment disorders. Thus are *diagnoses* – their names, specifications, grammars, logical forms, varying utilities, and the controversies informing them - precipitated.

If one examines the marks of madness, however, and the great range of diagnostic categories in the Diagnostic and Statistical Manuals of the APA, one finds that the marks of disordering and, more clearly, the range and types of disordered conditions classified and re-classified by psychiatrists differ considerably, in rough ways, from the pathological states to which neurologists attend.

Here is the question: While acknowledging the confusions, conflicts, problems of intelligibility and of utility etc. respecting the kinds of madness, *is there a concept of health, (largely tacit) operative in society which informs credible judgments that someone is mad and by which we can distinguish psychiatry as a medical specialty?* I believe there is. *Do we find this same concept operative in the practices and cultures of the psychiatrist, that is, a foundational mode of good organismic ordering (i.e., of a kind of good health) that is different from "the functional integrity of the nervous system" by which we have identified the sort of good health that is sought by the neurologist?* I believe we do. To identify this concept we turn to the second study.

What the Examination by the Psychiatrist Requires

To discern and illustrate the operation of this principle, reflect on the conventions and conceptual implications of the psychiatrist's intention in his relationship with the patient to reach a judgment regarding the current state of a patient insofar as the patient is or is not mad. The activities expressing this intention are distinguished and named as the process of interviewing, the discernment of why the patient (and/or others) has sought services (the complaint and the story of its genesis), the patient's life history and current circumstances relative to "the present illness," and the mental status examination. In this moment and with respect to the question of madness, the psychiatrist is engaged in the art of "assessing" a patient's current and past behavior and experience in order to evaluate the patient's capacity to conduct himself as a human agent.

For the purpose of this inquiry, focus attention on the implications of the mental status exam while understanding that these same implications can be and are inferred from the other elements of "the assessment of the patient."

This exam is commonly employed to discern and describe the marks of madness, i.e., to identify the current signs and symptoms of those adverse changes in the organismic foundations of a patient's affective states, reflective

consciousness, and behavior, etc., that for the psychiatrist confirms or fails to confirm the presence of madness (See example, Appendix One). *But if we reflect on the generic features of this exam, we find that identification of the marks of madness elicited by this exam must arise by way of contrasting the presence of these marks with tacit knowledge of what is normally present in the activities and experience of persons who are not mad.*

And so, we are led to a new question. What is normally present?

If we reflect on the marks of "passing the exam with flying colors," we can discern what is normally present – the presence and integration of a set of capacities for living a life in relation to others, and to all that is, through the exercise of one's own powers as a particular human agent.

These capacities, moderated in use by considerations of the age, stage, circumstances, social setting, cultural ideals, etc., and in reference to a particular life in progress, are as follows:

Capacities Implied by "Passing" the Mental Status Exam

- a capacity to actively live one's life in a way that is compatible with attempts by others to live their lives;

- a capacity to have more or less plausible apprehensions of one's relations with others - more generally, an appreciation of what is real and what is imaginary;

- the experience and operation of motives and affective states commensurable with the successful application via the activities of everyday life of the knowledge that one has acquired;

- a capacity to speak, think, and to successfully use language and other symbolic forms in new situations for purposes of discernment and communication, as well as for the coherent use of artifacts;

- a capacity to attend to and understand what one is doing and what others are doing, as well as what is happening;

- a capacity to hold intelligible, credible beliefs about oneself and others, and to possess accurate information about the circumstances with which one is confronted;

- a capacity to accurately sense, perceive, and re-present in thought what is given in "the manifold of experience";

- a capacity to remember what one has learned;

- a capacity for new learning relative to living a life;

- a capacity to move and to cease moving in keeping with that knowledge and to thereby to secure, in a continuing way, one's prudential interests under various sets of circumstances that are constitutive or could be constitutive of one's life.

- a capacity to judge more or less accurately of what to do to achieve one's aims in relation to others and to nature; insight as to one's condition as a particular agent.

For a person to manifest these capacities requires the successful functioning of his endowments and cultural acquisitions, i.e., what a person's biological endowments and lived experience have enabled a person to learn in the course of living his or her life. The endowments and acquisitions required for the successful operation of these capacities are, for the most part, organismically configured as habits of perception, cognition, and memory; emotional responses to stimuli; dispositions to engage in certain activities and in certain ways; a fund of habitual knowledge revealed in the use of language, gesture, and the staging of an appearance, etc. To evaluate the operational status of these capacities over time is to know the quality of both the process and the content of the behavior and experience of one's self or another.

When, together with knowledge of a person's current life narrative, the marks of the successful operation of *these capacities* signal that a person is able, in a continuing way, to secure his prudential interests, we do not (or should not) judge that a person is now discernibly mad or mentally ill – no matter what judgments we may make regarding his other states, or habits, or actions.

Notice that to know the details of a person's current life made possible by the operation of these capacities is one of the basic ways by which we identify a human individual as a particular person. In keeping with the aim of this investigation, we can now say the following: When employing the mental status examination, the psychiatrist is evaluating *the personality of an individual* in order to determine if his capacities of personal individuality (or personality) are sufficient to enable that person, in and through his activities, to secure his prudential interests.

We may go further. If states of madness are a form of ill-health in which the elements of personality are dis-integrated and in conflict with one another and with the person's knowledge and ability to choose what to do based on that knowledge, then the discernment that *these capacities, when successfully and durably integrated and operative in the life of a person, count as criteria for a kind of human health* - not simply for "passing the examination." This component of health has a name, though it receives virtually no attention under that name in the psychiatric literature. It constitutes, however problematically, the required first principle of psychiatry. It is the idea of *sanity* – sanity understood as a form of health and as a medical category. Sanity, as understood in psychiatry, is *that form of health or organismic capacity that a person enjoys when the elements of his personality are well enough founded, organized, developed, and integrated with one another, and with his knowledge and capacity to choose, so*

that a person is able in this way, by means of his actions, to secure his prudential interests. And just as every state of madness reveals the state of the personality of the individual, so too do states of sanity. Everyone who is sane is sane in his or her way, in keeping with a set of endowments and acquisitions operative, as one hopes, throughout the life cycle in states of affairs more or less unique to that individual.

It is by means of the medical idea of sanity that the categories of "health," "the normal," "functional integrity," "prevention," and "the goals of treatment," are finally established and re-established in psychiatry – and not by means of pointing to the results of an examination indicating that the criteria for the "normal functioning of the nervous system" have been met.

Aside from the general features we have set forth, 'sanity' (like 'madness') is a term that is "open textured" or subject in use to variable specifications, senses, valuations, and interpretations. Its use, or, more accurately, tacit presumption, can vary from person to person, even by the same person at different times, according to other organismic considerations, to the education of the speaker, to the social context, and from one political-economy and legal jurisdiction to another. Usage, meaning, and practical implication vary from culture to culture and from one historical epoch to the next because the expectations for human action change and so too, but in a more conservative way, does the schedule of normative expectations for human agents and their actions.

From a *logical* point of view, it is the diminution of sanity that ushers in the concept of madness as ill-health, and thereby specifies "the pathological," "the dysfunctional," "the untoward," etc. in psychiatry – even if we are moved to articulate the concept of sanity only because we have first encountered the realities of madness. In summary, it is with reference to the variable and positive norms for sanity, operating tacitly with reference to the conduct of the everyday life of individual persons, that *the diminution of sanity* is recognized as "madness," a judgment that in some or many ways a person lacks the organismic capacity to meet those norms.

The concept of 'sanity' is required and not only for the intelligibility of the psychiatric examination. It is a concept that is indispensible for establishing the coherence of psychiatry as a medical specialty. It is by reference to the norms of *sanity* that we distinguish psychiatric conditions from neurological conditions, and psychiatry, as a clinical practice, from other medical specialties.

Psychiatry is, then, that specialty of clinical medicine which understands the foundation, organization, development, and integration of the elements of personality of an individual from a dynamic, organismic point of view: in terms of human health, as 'sanity;' and in terms of ill-health, as 'madness' or 'mental illness.' Psychiatry interprets 'the organismic' as 'personality'; neurology constitutes 'the organismic' as the 'nervous system.'

The defining practical aim of clinical psychiatry, as a specialty of medicine, is to restore or maintain the sanity of individual persons – and to promote practices pertaining to the development of personality known to be likely to generate sanity. Because psychiatry has these distinctive and distinguishing aims, and because the forms of sanity and of madness are of so many sorts, clinical psychiatrists engage in a variety of practices and elaborate an array of theories that sustain and question these practices. Because the discipline of psychiatry is directed at informing us regarding what is known and useful for practicing the several arts of generating, maintaining and restoring sanity, this discipline contains a great diversity of terms, topics, and patterns of inquiry.

If the diagnosis of a psychiatric condition is relative to the norms of sanity applicable to particular persons, to the exceedingly complex nature of personality, and to the variety of ways in which personalities are constituted as "normal," or "healthy," we cannot expect any univocal "explanation" or "understanding" of the question of *why* someone is mad - or sane. Nor can we expect that only one sort of remedy will be efficacious across the spectrum of disorders that share the title, "psychiatric condition."

Part Three

At the beginning of this paper we cite authors who affirm or imply that because of "recent [and future] developments in the neurosciences." psychiatric disorders are, or will soon be demonstrated to be, diseases of the brain. For such reasons, these writers urge or imply that the practices and organization of care, the disciplines, the research agendas, the educational programs of psychiatry, ought to be identified with those of neurology.

In Part Two, resistances to these assertions are presented in several forms: clinical, epistemological, conceptual, logical, and linguistic.

Clinically, we have observed that the only human beings who are judged to be 'crazy' or 'mad' and therefore in ill-health are those persons expected by themselves and/or others to be able to conduct themselves as human agents; that any kind of madness is known by reference to experiences and observations of behavior relative to norms for agential performances and so refers to the personal individuality or personality of the person; that the possibility of asserting that someone is mad depends on largely tacit but operative norms of sanity considered as a form of human health; that the judgment that someone is in need of psychiatric help depends logically on the norms for sanity applicable to a particular person; and that the concepts and languages employed by psychiatrists are refracted by these considerations.

The proper aim of the clinical psychiatrist is to restore or maintain sanity - the functional integrity of personal individuality. Psychiatric disorders are not properly ascribed to the nervous system in the sense that neurological disorders are. We have said enough to assert that psychiatric conditions are not neurological disorders. These undesirable states are, instead, disorders of personality in the

sense we have set forth. Psychiatry has an identity that differs from that of neurology.

We have also asserted that the elements of personal individuality displayed in the experience and activities of a person are constituted by biological endowments as well as social-cultural acquisitions gained in the course of living. Human experience and behavior are composed in one way or another of what is in-born, i.e., of us but not determined by us, and what is acquired and, to some extent, determined by us. What does this point of view yield regarding the place of the findings of the neurosciences in neurology and psychiatry? How does this view enhance our appreciation of the differences between psychiatry and neurology, between neurological conditions and psychiatric disorders?

Two sets of propositions illuminate the different ways in which the neurologist and the psychiatrist employ the findings and principles of each other's specialties, and of assimilating and making use of the findings of the neurosciences.

Neurology, Personality, and the Neurosciences

The neurologist is interested in the personality of his patient insofar as aspects of the patient's personality manifested in behavior and experience reveal something that is useful to know (regarding diagnosis, treatment, rehabilitation, etc.) relative to the aim of restoring or maintaining the functional integrity of the patient's nervous system – the sort of health that neurologists seek for their patients. Because the aim of this specialty is the restoration and maintenance of the functional integrity of the nervous system, the neurologist, in addition to interest in knowledge of his craft, is particularly attentive to the correlations between behavior and experience and the findings of the several neurosciences. These are pr*ima facie* the kinds of sciences that are likely to generate findings that may be of use in improving the means of achieving the aim of this specialty.

Because of "the social construction of the brain" (brain plasticity) and the sensitivity of "the expression of genes" to the vicissitudes of living a life, we can *imagine* that some disorders, e.g., some dementias now generally thought to be simply "endogenous diseases of the brain" have complex origins. For example, epidemiological research suggests that the prevalence of some kinds of dementia are associated with whether people smoke, how they conduct themselves with respect to other risk factors for cardiovascular disease, the sorts of health care they seek and receive, and their level of education. (F. E. Mathews et al, 2013 and Kolata, 2013).

Psychiatry, the Nervous System, and the Neurosciences

Psychiatry is that clinical specialty of medicine that apprehends states of madness as relative to the variable norms of sanity. Psychiatry construes sanity as a healthy personality, and madness as a disordered personality. The psychiatrist is concerned about the nervous system of his patient insofar as the operations of that system reveal something about the functional or dysfunctional integrity of the patient's personality that is useful in restoring and maintaining the patient's sanity or in determining if that is in fact the primary task at hand. How is this interest demonstrated by psychiatrists?

Most importantly, clinically. Psychiatrists know (or should know), for example, that untoward changes in the structure and function of the nervous system (e.g., from brain tumors, infections, the toxicity of drugs, deficient oxygenation from cardiac arrhythmias) of a patient are sometimes initially manifested in clinical "end states" such as depression. Such states can and have been erroneously perceived as primary psychiatric conditions rather than as manifestations of other sorts of 'underlying' or 'primary' disorders of another sort.

As to education, it is important that the psychiatrist be knowledgeable, insofar as it is clinically relevant, about the ways in which the nervous system is formed, organized and disorganized; about its functions and malfunctions etc., not because "mental illness is brain disease," but because the functioning (and malfunctioning) of the brain is one of the many factors that underwrites the personality of individual persons in states of health and ill-health.

As to research, we here express no more than an attitude. The elements of personality, both endowments and acquisitions, are many and diverse. The dynamic organization and disorganization of these elements take myriad forms as they develop relative to the agency and life circumstances of particular persons. Moreover, to some extent, a person as agent, generates his or her personality. The origins of many states of madness are unknown even when they can be treated with some success or when they dissipate "spontaneously."

We can *hope* that we will learn more about how features of these states are "caused by" or associated with the patient's genetic endowment, or are linked to the patho-physiology of his brain, or to his immune or endocrine system, or to the patient's social history and his response to that history. Should psychiatrists affirm that states of sanity and different psychiatric conditions come about in different and multiple ways, that is, be determined by different arrays of endowments and acquisitions? Certainly.

But it is not logically, linguistically, philosophically, or scientifically *necessary* that all psychiatric disorders are or will turn out to be "diseases of the brain" any more than the marks and states of madness are *necessarily* just the end result of bad decisions or untoward interpersonal relations such as a lack of competent love or of domestic and social injustice.

In principle, the psychiatrist must be able to attend, not only to his patients and craft, but to findings of a wide and diverse set of sciences and humanities, - to whatever is known that has or could have practical implications

for the constitution, maintenance, and restoration of sanity. It is when such findings are *shown in practice* to improve the sanity of persons that they should take their place on stage in the discipline and dramas of clinical psychiatry.

Conclusion

In regard to the institution of medicine, psychiatry is like other specialties because it aims at securing the health, the organismic flourishing human persons. It differs from other specialties because it is primarily concerned in a practical way with the restoration and maintenance of sanity, a mode of human health. Because knowledge that one enjoys sanity or suffers a mental disorder is grounded in knowledge of the behavior and experience of persons, psychiatry construes the organismic as personality. It is in virtue of this construction and its reference (though in different states, a variable reference) to features of personality that are acquired in living a life in relation to others that psychiatry, among the specialties, displays within medicine a comparatively unique identity and set of problems.

States of madness should not be classified in keeping with the principle that such conditions are "diseases of the brain." States of sanity are not simply an indication of the structural and functional integrity of the nervous system. Psychiatry, as a medical specialty, aims at the restoration and maintenance of sanity, that well-ordered state of the personality of an individual that is organismically constitutive of person's capacity for human action and designation as a human agent.

Appendix One

Mental Status Examination*	Marks of Madness
Appearance	disheveled
Overt Behavior	aimless, purposeless
Attitude	belligerent
Speech	pressured
Mood and Affect	angry and jocular
Thinking	
Process	flight of ideas
Content	perseveration
Perceptions	hallucinations
Sensorium [Consciousness]	
a. Alertness	hyperalert
b. Orientation	disoriented to person, place, time
c. Concentration	93,39,? (can't subtract 7 from 100)
d. Memory	refused questions
e. Calculations	"Who cares?"
f. Fund of Knowledge	incommensurate with Hx
g. Abstract Reasoning	concrete or unintelligible
Insight	none regarding his state
Judgment	poor re consequences of actions

* *Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry*, Tenth Edition, 2007, Table 7.1-4, p. 233.

Footnotes

1. I shall not here examine the claims of these parties regarding the nature of psychiatric disorders.

2. Not all academic psychiatrists who are also neuroscientists espouse this proposition. For example, after reviewing the findings of "the behavioral neurosciences" and of "molecular genetics," Daniel Luchins asserts that "The last decades have witnessed remarkable development in the behavioral neurosciences, but without commensurate improvements in the provision of mental health care." He suggests that one explanation for this state of affairs is that," There are limits to what the behavioral neurosciences can explain." and asserts that "knowledge that lies outside these sciences remains essential for our field" (Luchins 2010, p. 395).

3. While reflection on this topic in the modern era owes much to Karl Jaspers (1959), other contemporary authors who have influenced in the formation of the stance espoused in this article include Allport (1961), Angyal (1958), Canguilhem (1966), Fulford (1989), Ghaemi (2003), Goldstein (1963), Hall and Lindzey (1957), Kandel (2006), Leifer (1997), Macmurray (1957, 1961), Margolis (1976), Pies (2005), Radden (1985), Straus, Natanson, and Ey (1969), Szasz (1974), and commentaries on and by Szasz in Vatz and Weinberg (1983). For two recent source books on the philosophical problems of psychiatry, consult texts edited by Radden (2004); and Fulford, Thornton, and Graham (2006).

4. The term 'organismic,' as applied to the apprehension and study of behavior and experience of singular individuals, is used throughout this paper in the sense described in a previous contribution. There it is suggested that "personality can be understood from an aesthetic point of view, as an organismic whole – as a harmony or attunement of those different and progressively differentiated and (as the individual grows to maturity) patterned behaviors and experiences that make action possible." Daly (1991, especially pp. 380-385). This paper applies the results of that previous work to the question of the difference between neurology and psychiatry.

5. Other goods generally esteemed as requisite for a good life are discussed in an introductory text by Frankena (1973). For a modern discussion of "a good life," see Ricoeur (1992, esp. Seventh and Eighth Studies).

6. "Prudential interests, then, are merely enabling interests, that is, the general (determinable) condition on which any ethical, political, economic program viable for a complex society must depend, in that sense, the pursuit of prudential interest is prima facie rational . . .." And, as "medicine has expanded its purview to include the concerns of mental health and mental illness . . . medicine in general must subserve, however conservatively, the determinate ideology and ulterior goals of given societies . . . ,", i.e., the non-prudential interests of the persons of a society (Margolis 1976, p. 252).

7. Plato reminds us that some states of madness are not perceived as problems of health but as "a blessing." In discussing whether the beloved should accept the lover or the non-lover, he has Socrates say, "I told a lie when I said that the beloved ought to accept the non-lover when he might have the lover, because the one is sane, and the other mad. It might be so if madness were simply an evil; but there is also a madness which is a divine gift, and source of the chiefest blessings granted to men." . . . [moreover, just as] prophecy . . . is more perfect and august then augury, both in name and fact, in the same proportion, as the ancients testify, is madness superior to a sane mind . . ., for the one is only of human, but the other of divine origin" (Plato, Phaedrus [244], 1952, p. 143). Dodds (1968, Chapter 4), "The Blessings of Madness," provides a classical analysis of these passages. See also Simon (1978, p. 185), in the context of his studies.

8. But the operative array of specialties is also shaped by the convictions of powerful individuals, law and public regulation, professional organizations and their norms, the array and dynamics of existing specialties and their quest for authority, competition with other organized occupations offering heath care, the vicissitudes of the political-economy, and, more broadly, the culturally-informed dramatic design of society itself. Horton (2004) provides a brief introduction to this topic. Consult Stevens (1998) for a scholarly history of medical specialties in the United States. Fifteen years ago, after arguing that "specialization is the fundamental theme for the organization of medicine in the twentieth century" (p. ix) she observed that "the medical profession is moving toward a system of specialties defined by the job market rather than by the professional system of specialist qualifications" (p. xxvi). Nevertheless, each medical specialty is still defined by its practitioners in accordance with distinctive principle(s). The American Medical Association lists 214 different "self-designated practice specialty codes" in its census of American physicians (AMA 2010).

9. The divisions of labor in clinical medicine are not always clear. Specialties (and subspecialties) can have overlapping "clinical jurisdictions," display different ideas and practices about the same clinical state of affairs, and engage in market competition with other medical specialists as well as practitioners who are not physicians. So or 'by and large,' or 'generally speaking.' And of course, there are unclear kinds of cases (e.g. autism, Tourette's syndrome, schizophrenia). What I shall say about neurology and psychiatry admits of ambiguities, ironies, uncertainties, and exceptions that cannot here be discussed. In addition, ignorance of the organismic foundations of "having a life" shrouds many problems pertinent to the question before us.

10. S. Nassir Ghaemi provides a brief but useful account of the construction and use of the 'ideal-type' method as developed by Max Weber (Ghaemi 2003, pp. 178-189).

11. This brief exposition of neurology has its origins in the author's limited experience in clinical neurology, as a

psychiatric and ethics consultant regarding the care of patients attended by neurologists and neurosurgeons, and by familiarity with the standard text on clinical neurology edited by Ropper and Samuels (2009).

12. Neurology, as a distinctive practice and discipline, came into being as a medical specialty in the first half of the nineteenth century. In the nineteenth century, madness was differentiated from neurological conditions if the clinical state was not correlated with demonstrable cellular pathology because only the appearance of atypical cells in the brain conformed to the rule for identifying 'the pathological.' This tradition has long sustained the view among some physicians that psychiatric disorders are just neurological disorders awaiting the discovery of lesions at some level of cerebral organization and function e.g. Guze (1989) – or – that they are not medical disorders at all e.g., Szasz (1974, p. IX). For more on the history of neurology and psychiatry, see Brown (2008), Grob (2008), and Stevens (1998, pp. 222-225).

13. In accounting for the principles distinguishing psychoanalysis, psychiatry, and neurology, Mace (2002, pp. 67-68) informs us that, "The first development was a move by neurology to disown any "functional" disorders that lack an anatomical basis . . . by the shift in its envelope away from the spreading terrain of psychiatry."

14. For an account of these conditions, read Lishman (2009). "Madness" in these conditions is known as a manifestation of a neurological or other medical condition. In other states of affairs entailing injury to the brain or other parts of the body credibly believed to be a result of activities and experiences that signal some form of madness, e.g., injurious suicide attempts, the injury is said in clinical parlance, to be "secondary" to another condition, for instance, depression.

15. A variety of writers acknowledge this beginning point: "It is within the everyday world that the individual first comes to recognize the signs of disease, and it is within the confines of his naïve immediacy that he comes to grasp the meaning and status of what is deemed normal." (Goffman, 1961, "The Prepatient Phase," pp. 131-146); . . .. We receive no formal initiation into the normal; we do come to learn, however, that the inversion, pathology, and destruction of the normal is a possibility of daily life" (Straus, Natanson and Ey, 1969, p. VIII); "The doctor is called by the patient. It is the echo of this pathetic call which qualifies as pathological all the sciences which medical technology uses to aid life" (Canguilhem, 1991, p. 176).

16. The statistical findings, and the difficulties associated with those findings, which purport to estimate how common are lay judgments regarding various forms of madness by the population of the United States can be found in Frank and Gelid "The Population with Mental Illness (2006, Chapter 2)." Clearly, the judgment that someone is mad is common.

17. Of course, in some cases, upon review, these claims and beliefs may prove not to be credible. But in many cases that find their way to the psychiatrist they are credible, and it is with these judgments that we are concerned. Further, I am not asserting that there are medical grounds for all the claims for services that are in fact brought to the attention of psychiatrists, nor are these reflections intended to justify all the practices in which psychiatrists engage.

18. These are not rules for identifying a person as mentally ill - that is, "if these five elements of the judgment are demonstrated, then a person is mad. " My intention is to show that if someone is judged mad, then the features of sound judgments will include what I am asserting about the nature of madness and of sanity with respect to persons considered as agents.

19. Herman Melville offers a precise formulation of this difficulty: "Who in the rainbow can draw the line where the violet tint ends and the orange tint begins? Distinctively we see the difference of the colors, but where exactly does the first one blendingly enter into the other? So with sanity and insanity. In pronounced cases there is no question about them. But in some supposed cases, in various degrees supposedly less pronounced, to draw the exact line of demarcation few will undertake, though for a fee becoming considerate some professional experts will. There is nothing namable but that some men will, or undertake to, do it for pay.

Whether Captain Vere, as the Surgeon professionally and privately surmised, was really the sudden victim of any degree of aberration, everyone must determine for himself by such light as this narrative may afford." Melville [1886-1891], (1962, p. 102).

This difficulty of judging whether someone is mad is experienced by the person in question in terms of "self designation" and by others by way of "accurate reference" regarding the agency of another. See Ricoeur (1992, pp. 35-39) for an analysis of "self ascription" and "identifying reference" in his commentary on "The Primitive Concept of a Person."

20. Certain conditions, both psychotic and non-psychotic, clearly count as diminutions of sanity and are properly judged to be states of "madness." Other states, like unhappiness, or grief, do not. See Wakefield [1992], (1997, p. 64), for further details about what does not count as a 'disorder.' But even if we have clinically useful definitions, criteria, and knowledge of the exemplary marks of these states – and of clear cases – there will be unclear cases and occasions when practitioners will be uncertain about or inconsistent in the application of these terms. On some occasions, the question of whether someone is mad, or of the kind of madness that he suffers, will be of great clinical importance. At other times, in the midst of the relationship with the patient, these terms, and concerns about their application, may be best placed at the far horizon of the patient's and practitioner's consciousness.

21. This is an illustrative, not taxative, list. For a complete inventory see DSM-5 (2013). Not every category on this list satisfies a strong or clear sense of "madness" but serves, among other

purposes, various research agendas, the aims of public agencies and insurance companies, the desires of psychiatrists to be compensated for their services, and the effort to make practices more manual-driven.

22. The mental status examination is a repeatable, systematic, clinical test used to access, according to standards, the operative agential capacities, abilities, or powers of action of a person. It is one of the means employed by psychiatrists to reach a judgment regarding the current condition of a person insofar as he is or is not mad. Here we present an alternative way of apprehending, in the paradoxical language of medicine, the meaning of the "negative" results of history-taking and this exam. For a detailed description of the psychiatric examination consult *Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry* (2007, Chapter 7).

23. "Where it [pathology] points to a breach or rent, there may normally be an articulation present," Freud (1933, pp. 58-59). Canguilhem (1991, pp. 43-46) draws attention to the history of this idea in medicine and philosophy in the nineteenth century.

24. While Jaspers (1959) does not use the *term* 'sanity,' we find foundational discussions of our question and of health and illness in many places in this text. (See, for example, pp. 779-789, and with regard to the classification of madness, pp. 604-616). Offer and Sabshin (1966), in a still influential book, discuss the problem of "normality" but offer no comments on sanity as a component of health. Nor are there sustained discussions of 'sanity' in the contemporary texts edited by Fulford, Thornton, and Graham (2006) or Radden (2004). What is found in these and other texts – e.g., Ghaemi (2003, esp. chapter, 10) and Radden (1985, esp. chapters. 4, 5) – are commentaries on "mental health" or on "unreason" Radden (1985).

25. The term 'insanity' has an important place in the history of legal reasoning and public law pertaining to competency to stand trial, to be executed, and regarding responsibility for illegal acts. For a brief introduction to these matters read *Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry* (2007, pp. 1377-1381). In this paper, the use of madness is intended in a strictly modern medical sense.

26. An abundance of terms are employed to specify (with varying degrees of credibility and utility) why or how the composition, development, or arrangement of personal individuality is altered in the disordered states of persons who are judged to be mad. These terms, predicated of one or more elements of personality, include the following: 'conflict,' 'absence,' 'deficit,' 'excess,' 'error,' 'deficit,' 'deletion,' 'deprivation,' 'failure,' 'fault,' 'loss,' 'split,' 'trauma,' 'weakness.' These terms, together with their empirical referents, ground more global characterizations of states of madness, as, for example, 'degenerations,' 'disintegrations,' 'disorganizations,' 'dysfunctions,' and 'regressions.' All these terms and their cognates, when employed in psychiatry, express and depend, for their generation and conceptual integrity, on a background distinction between sanity and madness.

27. The elaboration of a more complete theory of sanity as a component of human health is beyond the scope of this communication. Here, the concern is with the place of 'sanity' in the constitution of psychiatry as a medical specialty. The *Synopsis of Psychiatry: Behavioral Sciences/ Clinical Psychiatry* (2007, pp. 12-18), provides an elementary introduction to the topic of "normality". Complex and refined sources for the development of a theory of sanity may also be found, among other places, in the texts cited in Note 3.

28. This variability does not mean that such tacit presumptions are *prima facie* unintelligible, or, that interest in what is found to be common to these states of persons in various epochs is in principle unjustified. If the author believed otherwise, he would not have written this paper. But, because the use of these terms serves malign as well as benign aims, it does mean that the studies of who makes these judgments, about whom, and what follows from ascribing sanity or madness to persons, are worthy of critical attention in understanding the origins, practices, and discipline of psychiatry. Recall the numerous works of Thomas Szasz which portray malign aims and practices.

29. In this regard, note two recent publications. Kenneth S. Kendler, noted for research on the genetic causes of psychiatric disorders and addictions, has reviewed the empirical research on the distribution of eleven "'difference markers' (aka causal risk factors)" in schizophrenia, major depression, and alcohol dependence. He reports that "the causes of psychiatric illness are dappled, distributed widely across multiple categories" (Kendler, 2012). Second, the NIMH launched a new effort to "Develop, for research purposes, new ways of classifying mental disorders based on dimensions of observable behavior and neurobiological measures" . . . the Research Domain Criteria Project (RDoC). ". . . It is hoped that by creating a framework that interfaces directly with genomic, neuroscience, and behavioral science, progress in explicating etiology and suggesting new treatments will be markedly facilitated." (Research Domain Criteria (RD0C)) 2011. But in relation to these publications, the argument set forth in this paper is concerned with depicting and understanding *that which is in need of explanation* – with an *explicandum*, not an *explicans*. (Daly, 1991, p. 370.)

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Commentaries

The Two Sources of Psychiatry

Eric v.d. Luft, Ph.D.

Robert Daly seeks to define "sanity" and to place this concept in the context of the historical, theoretical, and practical development of psychiatry. Yet such a quest can prove elusive. In the famous "contract scene" from *A Night at the Opera* (Trahair 2007, 200), the following dialogue occurs between Otis B. Driftwood (Groucho Marx) and Fiorello (Chico Marx):

> Fiorello: What does this say here, t his thing here?
> Driftwood: Oh, that? Oh, that's the usual clause that's in every con tract. That just says, uh, it says, uh, If any of the parties participating in this contract are shown not to be in their right mind, the entire agreement is automatically nulli fied.
> Fiorello: Well, I don't know .
> Driftwood: It's all right. That's in every contract. That's what they call a sanity clause.Fiorello: Ha ha ha ha ha! You can't fool me. There ain't no Sanity Claus!

This comedic bit, along with countless other examples from popular culture and everyday life, shows that the very notion of sanity, however we may understand it, and even if we do not understand it, almost automatically creates or implies a divide among humans. There are those who possess the property of sanity, and those who do not. This divide is universally recognized, even if its precise demarcation is not. Even if we agree with Thomas Szasz that there is no such thing as "mental illness," we must

still admit that the idea of sanity is implicit, intelligible, intuitive, and useful, albeit difficult to define.

Daly's present article forms a natural continuation of his "A Theory of Madness" (1991), in which he systematically considered the pros and cons of several possible explanations of madness as action, predicament, condition, ostracism, imprisonment, estrangement, dysfunction, ignorance, illness, abnormality, disintegration, etc. He concluded that madness is a state of human agency in which the agent's actions constitute "a diminution sufficient to impede her ability to secure her prudential interests" (Daly 1991, 384). Now he sets out to investigate the converse of madness, sanity, for which a minimal condition is "a capacity for reflective consciousness" (Daly 1991, 383).

Some may equate sanity with sobriety, calmness, moderation, or "not rocking the boat." Madness, then, would be evidenced by crazy, disruptive, unconventional, or blatant behavior. Yet even such madness, if there is method in it (cf. *Hamlet*, II, ii, 205-06), could be calculative, deliberative, orderly, productive, advantageous to one's best "prudential interests," or, in a word, sane. The stereotypical Irish character is a case in point: "Freud ... muttered in exasperation that the Irish were the only people who could not be helped by psychoanalysis" (Cahill 1995, 150). The Irish wit, Oscar Wilde, and the Irish Republican playwright, Brendan Behan, were both crazy, disruptive, unconventional, and blatant, but no one should deny their sanity. Both made bad choices, but not because they were incapable of making good choices or because they did not have sufficient instincts toward what Daly calls their "organismic ability to secure their prudential interests." Rather, they just made mistakes, as we all do. Behan was crude, and his crudity was enough to turn some genteel people away from being able to appreciate his plays. He was, after all, by his own admission, not a writer with a drinking problem, but "a drinker with a writing problem." All the same, this crudity, though natural to him, was not gratuitous, and indeed it contributed in a major way to make, emphasize, or illustrate the sociopolitical points that were part and parcel of his plays. If he sought in *The Hostage* to reveal the Irish Republican Army, its ideals, and its pride as refuges for the degenerate, the decrepit, the criminal, and the hopeless, then what more sensible way to do so than to put the seediest underside of Dublin society on stage? Quite sane.

There are some actions which may at first seem insane, but which, upon further scrutiny, are revealed as sane, logical, or even obligatory for a civilized person within a certain culture. For example, after fulfulling a long-held dream by winning the light heavyweight boxing gold medal at the 1960 Olympics in Rome at the age of only eighteen, Muhammad Ali (then Cassius Clay) deliberately threw this medal into the Ohio River where, presumably, it remains to this day. But the facts of his motivation show that this deed was not at all insane. The medal had been awarded not only to himself, but also to his country. As soon as he discovered that it did not exempt him from Jim Crow laws or his country's vicious and deeply ingrained racism, he thereafter regarded it as worthless (Ali 2004, 38-41). Again, quite sane.

Yet there are some psychiatrists who believe that they can judge a person's actions as sane or insane just by clinical observation and systematic classification of personality, without either listening to that person's story or even learning much about that person. Hence some philosophers, polemicists, and critics, e.g., Jenifer Booth (2013), argue against the authoritarianism, paternalism, and know-it-all-ism that some psychiatrists exhibit toward their patients. She contends that psychiatry, in order to be true to its healing roots, must become less enthralled by highly technical scientific concepts, more attentive to patients, and more virtuous in the classical Aristotelian sense. Among the manifestations of this captivity to jargon is, as Daly points out, the current revision of the *Diagnostic and Statistical Manual* (DSM), i.e., the standard by which personality is to be systematically classified following clinical observation.

I believe that Daly is on the right track to describe sanity as that quality by which one is self-sufficiently capable of acting in pursuit of one's own best prudential interests as a member of civilized society. This self-sufficiency would, of course, be relative by degrees to one's age, so that, for example, the word "sane" would be meaningless with regard to newborns, for whom self-sufficiency or purposefully directed initiative or deliberative action is impossible. However, even someone as young as a toddler could be deemed either sane or mad in certain situations and could thus be a candidate for age-appropriate psychiatric care.

To define "sanity" seems more difficult than to define "madness." Perhaps that is because madness seems naturally more interesting than sanity. Both definitions would require, as Hegel recognized (Mills 2002, 159-64), a philosophical consideration of human ontology in both its "normal" or "healthy" and its "abnormal" or "diseased" states. For Hegel, madness was an illness, an "abnormal" falling away from the "normal" social integration (*Sittlichkeit*) (Hegel 1955, 139-48) that ideally had a reciprocal and symbiotic relationship with the individual or subjective sanity of the free members of any well-ordered society. Despite his ontologizing of madness and sanity and his consequent belief in "mental illness," Hegel remains much closer to deniers of such ontology, e.g., Szasz (2011), than some scholars, e.g., Daniel Berthold-Bond (1995, 177-202), admit, insofar as Hegel saw the locus of madness/sanity as spiritual (*geistlich*) and subjective rather than as anything physical and acknowledged the sociopolitical dimension of labelling some people as "sane" and others as "mad."

Daly claims that Jaspers does not use the word "sanity." The fact is that there is no single German word or phrase that directly corresponds to the English "sanity." In the German editions of *Allgemeine Psychopathologie*, Jaspers (1973) uses *geistige Krankheit* ("mental illness") but not its correlative, *geistige*

Gesundheit ("mental health"), although he does occasionally use *gesunder Verstand* (literally "healthy understanding"), *Zurechnungsfähigkeit* (literally "capacity for attribution"), *Menschenverstand* (literally "human understanding"), and *Vernunft* ("reason"), which are all common German euphemisms for "sanity." Yet for all that, Daly's point is well taken that Jaspers is more concerned to describe madness than sanity. Pathological or unusual conditions just seem generally more interesting than healthy or ordinary ones.

Daly sees that we must investigate the history of psychiatry in connection with any inquiry into the meaning of "sanity." That is because psychiatry arose out of a fundamental concept - or several competing fundamental concepts - of "madness." Given that "sanity," whatever it is, is the opposite of "madness," we must investigate both to understand either one adequately. The history of medicine in general, and of psychiatry and neurology in particular, can enlighten not only our philosophical ideas of aspects of human ontology, but also our practical therapeutics based on this ontology.

Psychiatry has a twofold root: counseling and neurology. The former arose in prehistoric antiquity, the latter in the eighteenth and nineteenth centuries. Especially in the German-speaking world in the nineteenth century, the emergence of clinical neuroscience and the slightly later development of Freudian psychoanalysis created a "turf war" among physicians treating psychiatric patients (Foley 2012, 184-87). Consequently, even at the dawn of the third millennium, psychiatry, broadly conceived, remains manifest in two general camps, which I will call the "holistic" and the "physicalist." Both camps are very large and each contains many different approaches to patient care. The former, informed by the view of non-physical mind and physical body as distinguishable if not separate entities, includes such activities as couch therapy, pastoral counseling, transactional analysis, group therapy, couples therapy, the psychotherapeutic methods of Carl Rogers, and umpteen forms of "talk." The latter, dependent on the idea that the mind can be exhaustively understood in terms of physical causation, includes aversion therapy, shock therapy, behavior modification therapy, lobotomy and other psychosurgery, many types of chemotherapy or psychopharmacology, the fictional Ludovico Technique (Burgess 1965, 83-128), other violent, cruel, or invasive means of achieving permanently reliable passivity in patients, and even the psychedelia of Timothy Leary and moderate denials of free will (e.g., Ravven 2013). In the holistic camp are Pinel, Jung, Fromm, Adler, Eric Berne, and paradoxically, even though he was trained as a neurologist, Freud. In the physicalist camp are Benjamin Rush, Franz Joseph Gall (Lantéri-Laura 1993), S. Weir Mitchell, Egas Moniz, Walter Jackson Freeman (Raz 2013), and most paternalistic or unilateralist interventionists.

Even when psychoanalysis or other kinds of "talking" psychotherapy are informed by cognitive neuroscience, or even when the counselors among psychiatrists anchor their therapeutic methods in the findings of hard physical science, these methods still fall within the holistic camp. That is because holistic clinicians, however wide or eclectic their arsenal of examination, ultimately base their diagnoses, prognoses, and treatment programs on what they learn by *listening* to patients, rather than by examining them. Listening shows respect for patients, and thus gently guides them toward sanity by helping them to discover or identify their own best prudential interests and the best ways to act freely, originatively, or, as Daly would say, "organismically," to secure these interests. In other words, holistic psychiatrists help patients to reconstitute their "organismic ability" to live freely and happily in society. Drugs and other physical means cannot achieve this goal of integrative healing, although they may alleviate symptoms. Patients recognize and benefit proportionately from whatever degree of respect their physicians show them. Mutual respect in the patient/psychiatrist relationship can lead eventually toward the restoration of real sanity, while imposing treatment shows arrogance toward patients, and creates in a patient, if successful, only the caricature of sanity. It may not be too much of an oversimplification to say that holistic clinicians, like counselors, wish to develop a certain closeness, not friendship or intimacy or some other potential conflict of interest, but a creative or constructive rapport with their patients; while physicalist clinicians, like surgeons, wish to maintain a certain professional distance from their patients. This distance may be (mis)interpreted as paternalism, which the history of medicine since the mid-twentieth century has shown to be counterproductive. Yet perhaps a fear among those psychiatrists who identify mind with brain is that, if psychiatry becomes too holistic or too humanistic, then it may lose its "special relevance to medicine" (Szasz 1973, 229).

Whichever position we take on the origins of psychiatry must be consistent with the philosophical position we take on the mind/body problem in general (Burkhardt 2002, 148). Indeed, it would make little sense even to consider the origins of psychiatry unless we have first considered the mind/body problem (Wallace and Gach 2008, 685-834). This dependence of our respective conclusions about the origins of psychiatry upon our respective philosophies of mind means only that our complementary concept of "sanity" versus "madness" should be grounded in ontology, i.e., in a systematic account of what properly constitutes the whole human being, whether "sane" or "mad."

The mind/body problem, except for nuances, was not very controversial among philosophers in the Platonic, Aristotelian, and Christian West until Descartes reformulated it in the late 1630s. That is, prior to Descartes, the effective interaction between soul and body, spirit and flesh, or whatever we wish to call it, was assumed more or less as a given, the mechanics of which were not much considered. But Descartes defined the strict metaphysical dualism between the thinking "I" (*res cogitans*, the perceiving subject) and the extended world (*res extensa*, the perceived object) in such a way that people had to wonder how these two poles could ever

interact with each other. This reformulation sparked not only immediate and intense reaction, e.g., in the seven sets of objections and replies to his *Meditations* of 1641-1642 (Descartes 1931, vol. 1, pp. 131-99, and all vol. 2), but also new and revolutionary divergences in philosophy, which took Descartes as both their starting point and their whipping boy, e.g., the monism of Spinoza, the pluralism of Leibniz, the empiricism of Locke and Hume, the critical epistemology of Kant, and the idealism of Berkeley, Fichte, Schelling, and Hegel. Even Descartes himself, sensitive to this weakness in his foundationalist system, sought to gloss over the difficulty by positing the involvement of "animal spirits" and the pineal gland.

Among post-Cartesian theoretical innovations are various species and degrees of physicalist reductionism, e.g., phrenology, behaviorism, epiphenomenalism, mind/body identity theory, etc. Typically such theories reduce the mind to the brain. They see human initiative action, subjectivity, and free will as expressions of physiological, biochemical, or neuromechanical processes; and spirit, soul, and even sometimes mind itself as romantic fantasies or infelicitous terms, denoting nothing, or nearly nothing, at best epiphenomenal.

Daly borrows from certain predecessors a rather unusual term, "organismic," which, despite the easy temptation to read it as a crasis of "organic" and "orgasmic," means nothing akin to either, but instead refers adjectivally to the integrated and internally harmonized being of the whole organism (Daly 1991, 381). Daly's favorable use of this term associates him with the anti-physicalist theory of Edward Pols, according to which any originative human action comes from the mind, not the brain, and the various physical events in the brain and body which always accompany any such action constitute its necessary infrastructure, but not its essence. Perhaps the earliest systematic use of "organismic" which is consistent with the thought of both Daly and Pols is in the monumental neurophysiological treatise of Thomas Laycock, who writes therein that "all the faculties of experience are primarily modes of organismic energy, whereby the alimentation, protection, and healthy existence of the individual are secured. They are the Self-seeking, or Egotistic Faculties" (1860, 102). By "egotistic" Laycock does not mean "selfish," but rather something like "self-preserving" or "naturally inclined toward securing one's own prudential interests." None of what I say here is to suggest that Laycock, the theorist of reflex brain action, would agree with either Daly or Pols on the mind/body problem, but only that his use of the term "organismic" is consistent with theirs.

While it is true that psychiatry depends on neurology, which depends on physiology, which depends on chemistry, which depends on physics; it would be wrong to suggest that a perfected psychiatry would be reducible to a perfected neurology, which would be reducible to a perfected physiology, which would be reducible to a perfected chemistry, which would be reducible to a perfected physics. Each of these dependent sciences has a different way of understanding the same phenomena, which adds a different and typically "higher" point of view to that on which it depends. "Lower" sciences do not need "higher" ones, but each "higher" science needs all of those "beneath" it. For example, chemistry needs physics, but physics does not need chemistry; and psychiatry needs neurology, but neurology does not need psychiatry. This is not to say that physics could usurp chemistry, nor neurology psychiatry. There is a hierarchy of sciences, but neither an axiological equivalence nor a practical reduction among them.

In keeping with this hierarchy, Daly correctly asserts that the healthy structure and function of the brain and nervous system are not equivalent to "sanity." "Health" from the neurological point of view is not the same as "health" from the psychiatric point of view. Neurology studies the physical infrastructure of human originative action, not the originative action itself. Psychiatry studies the originative action, i.e., what makes any given person into *this particular* person. In other words, the province of neurology is the structure and especially the function of the brain and nervous system, but the province of psychiatry is the personality and especially the will, because, as Shakespeare's Caesar rightly claims: "The cause is in my will" (*Julius Caesar*, II, ii, 75). A healthy and smoothly functioning *physical* brain and nervous system is a necessary but not sufficient condition for "sanity." However, the integrity and prudent motivation of the individual will may just be this sufficient as well as necessary condition. Hence, because it takes a physicalist approach which seeks to reduce what is essentially non-physical, non-quantifiable, difficult to access unless the patient cooperates, and perhaps undefinable, to what is physical, quantifiable, relatively easy to access through empirical means, and probably definable, neurologically rooted psychiatry is misbegotten. While physicalist psychiatry considers the person as a physiological organism, holistic psychiatry considers the person as an *agent*, i.e., as an organism who, via physiological infrastructure, is capable of originative action by a free exercise of will. Daly notes that neither madness nor sanity can be properly understood unless as properties of persons as agents. If we are ever to learn what "sanity" really is, then studying neurology for this purpose is a dead end, because neurology cannot study the will. Even psychiatry may ultimately be inadequate for this purpose, since only philosophy can study the fundamental ontology of human agency.

Among philosophers who have explored human agency, free will, originative action, the physiological infrastructure of causality, and related topics in depth, Pols articulates a systematic hierarchic biology based on the data of the various natural sciences to account for the emergence, integrity, and operation of free human consciousness (Luft 1987, 27-9). Pols aims to define, in accord with both the physical sciences and the data of observed human behavior, a metaphysical structure into which consciousness, free will, self-identity, and originative action make sense,

logically fit, and may be explained with neither compromise nor resort to physicalism (Pols 1975, 38-68). The supervening ability of a person to be a cause in the world, i.e., to originate a chain of causality which activates, within the organism of that person, a physiological infrastructure which eventually has physical effects, he names "ontic power" (Pols 1975, 332). By virtue of its ontic power, the human mind earns its place at the apex of the causal hierarchy within its immediate world. Its actions are "rational" because they are informed by reason, even if that reason may occasionally be mistaken. Pols (1998, 121-37) further describes ontic power as the "causality of primary beings." A "primary being" is any rational agent capable of originating action. "Rational" in this context does not necessarily mean "sane," but rather something more akin to "capable of sanity" or, theoretically, under ideal conditions, "capable of acting in a sane manner." In any case, any "rational" act, for Pols, could also and easily be judged either "sane" or "insane" by either trained health care professionals or members of the laity.

In a way which seems consistent with Daly's project, Pols seeks to assert the positive powers of the human mind as a causal agent capable of sustaining, altering, or bettering one's own situation in the world, i.e., capable of furthering what Daly calls one's "prudential interests." In so doing, Pols attempts to overturn an age-old "negative philosophical judgment" that the "mental functions of human beings" and the "powers of the mind" do not include causality (Pols 1998, 96). In other words, Pols believes that, under normal, non-heteronomous, or non-coercive circumstances, each human mind knows what is best for it and can act toward such goals. Beyond Pols, we might even say that if a non-damaged brain can express a mind that acts freely and in its own knowable best interests, then that person is "sane"; but if, on the other hand, a brain, either damaged or non-damaged, expresses a mind that acts, either freely or under coercion, in ways which may be demonstrated to be not in its own knowable best interests, then that person may be somewhat less than "sane." That is, even the most fully "sane" mind would require a soundly functioning neurophysiological infrastructure in order to be an effective cause or a positive force in the world. None of this is to deny that even the most extreme or obvious "madness" could still be expressed through the most nearly perfect infrastructure imaginable. A healthy brain does not entail a healthy mind, and vice versa.

In the end, Daly's idea of sanity seems to imply a shared humanity. That is, one cannot be sane in isolation, but only in civilized society. Sanity is thus a necessary (but not sufficient) quality of the "democratic personality," according to which "the citizen recognizes that his or her well being depends on the well being of others" (Daly 2005, 83). This is in keeping with Daly's final assessment of sanity as a characteristic property of a well-ordered personality in a person who is organismically capable of free choice, initiative agency, and originative action in pursuit of that person's best prudential interests, which, after all, are consistent with the best prudential interests of the entire well-ordered society in which that person lives. As humans are social animals, so sane humans can be neither hermits nor misanthropes. Rather, we must each foster our individual sanity by aspiring to social ideals of Aristotelian friendship, Hegelian *Sittlichkeit* ("ethical order" or "coherent social morality"), Hebrew *chesed* ("loving kindness"), or Christian *agapê* ("universal love"). In other words, to be sane, be a sympathetic person of integrity, honor, decency, and tolerance.

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Should Neurology Become Psychiatry?

Robyn Bluhm, Ph.D.

Robert Daly considers the claims that psychiatric disorders should be reconceived of as brain disorders and that psychiatrists should be educated as clinical neuroscientists. He argues against these claims, in large part because psychiatrists and neurologists occupy very different positions with regard to understanding the patient and his/her problems. Whereas, according to Daly, neurologists are interested in a patient's personality insofar as it reveals something about the functioning of the patient's nervous system (p. 23), psychiatrists focus on the patient as a person and aim to restore the person – rather than the brain – to a state of health. In some cases, this may require attending to the "health" of the nervous system as a means, but for neurologists, the health of the nervous system is itself the end of medical intervention.

In making his argument, Daly defines "madness", the form of ill health relevant to psychiatry, as being composed of several features; (1) diminished capacity to secure one's prudential interests; (2) a loss of agency, so that one's behavior is caused by factors that are not truly those of the agent him/herself; (3) the manifestation of "marks of madness"; (4) the patient's being, as an agent, not rightly ordered; and (5) affective distress.

With the exception (possibly) of "marks of madness", the ill health that Daly describes is different only in degree, not in kind, from ill health caused by "physical" disorders. I do not mean just that physical disorders are often associated with the experience of "mental" disorders such as depression or anxiety. Rather, I suggest that serious illness of any sort affects agency and one's sense of being able to live life in accordance with one's own interests and goals.

Lennart Nordenfeldt's theory of health as the ability to achieve one's vital goals is an example of what I have in mind here. Nordenfeldt's theory is a normativist account of health and disease, meaning that it views judgments about disease as having an ineliminable value component. This type of approach is contrasted with "naturalist" theories, such as that of Christopher Boorse; Boorse defines disease in terms of malfunction or statistical abnormality of biological processes. Daly's description of neurologists as being concerned with the health of the brain reflects the naturalist view. By contrast, psychiatrists are concerned with the whole person. For Nordenfelt, as well, the concept of health must be understood from a holistic approach that "focuses on the general state of a human being and considers whether or not the person is healthy. This means asking questions such as the following: How does the person feel? What is he able to do? Can he function in a social context?" (1995, pp. 11 – 12). These questions, obviously, cannot be answered by attending to organs or organ systems.

Clearly, as Daly points out, treating the underlying biological abnormality is often relevant to restoring health. But the purpose of treating the *physical* disease is to restore the *person* (as far as possible) to health. To the extent that neurologists really do concern themselves with the health of the brain, they are missing the point of health care. Daly is correct, I think, to view the purpose of psychiatry as the restoration of a person's agency, using whatever techniques and approaches might help to achieve this goal. But this is not, or should not be, a goal unique to psychiatry. If other medical specialties fail to recognize this as the goal of medicine, they should aim to model psychiatry, not the other way around.

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A Problematic Paradigm for Psychiatry

Lloyd A. Wells, M.D., Ph.D.

Robert Daly has made a strong and scholarly effort to define the specialty of psychiatry and delineate it from the specialty of neurology by reference to the concept of sanity.

Starting with a description of the classification system in psychiatry, he points out the current view of many psychiatrists (and advocacy groups) that psychiatric disorders are disorders of the brain and rejects this assertion. He outlines a different model based on the concept of sanity. There is an implicit reduction that one must accept the premise that psychiatric disorder is either brain disease or Daly's proposed alternative. In fact, there are a great many possibilities.

I strongly agree with Daly's view that psychiatry is not neurology. . This reductionism seems to me to be absurd, at least at our current level of understanding of brain mechanisms in psychiatric disorders. One could make a similar and equally robust case that psychiatry should be a subspecialty of medical genetics, given genomic findings in many psychiatric disorders. Psychiatrists care for patients with Creutzfeld-Jacob Disease, which is caused by ingestion of prions. A few cases of severe obsessive-compulsive disorder are apparently caused by a post-infectious, immunological disorder. Does this mean that psychiatry is also Infectious Disease and Immunology?

I have four major criticisms of his paper:

1) One cannot propose that psychiatry deals with insanity only when insanity has no medical basis: increasing medical bases will be found. Psychiatry deals with insanity irrespective of its etiology.
2) The paper would benefit from more regard for history.
3) One cannot base a concept of "sanity" on the mental status examination, especially an abbreviated version of it as expressed in an abbreviated textbook.
4) Psychiatry should be viewed in part as a specialty which deals with perspective, empathy and solace.

I shall discuss these sequentially.

(1) I think it is an artificial distinction that "insanity", to be in the province of psychiatry, must not have a "medical" basis Here, I believe, Daly is on extremely shaky ground, and his argument merges with one he is attempting to refute – that psychiatric disorder is "brain disease". Proponents of this position argue that the neuropathology of most psychiatric disorders is present but as yet not defined. Daly would seem to suggest that, as it is defined, these disorders become, *de facto*, neurological. It is likely that most "insanities" may have a medical basis, but they remain in the expertise of psychiatrists. The entire field of consultation-liaison psychiatry deals with "insanity" which has a "medical" basis and is a very rich component of psychiatry.

At one point Daly indicates he will demonstrate how a psychiatrist and a neurologist would each approach a case of movement disorder – but he does not really do so. This would have been an interesting component of his paper, since both psychiatrists and neurologists treat some patients with movement disorders, such as tic disorder. In my experience, neurologists and psychiatrists who treat these patients use the same medicines and make rather similar hypotheses and conclusions about possible psychological and social factors. Some psychiatrists may do a bit better than many neurologists in addressing these psychological and social factors, while some neurologists may do a bit better with biological treatment. Tic disorders have a rich history at the interface of psychiatry and neurology. Charcot, a gerontologist who gave us the fundamentals of the modern neurological examination and who made enormous contributions to psychiatry is alleged to have said in a lecture that tics are a significant gesture. If one agrees with Daly that neurologists treat diseases of the nervous system and psychiatrists treat insanity, one wonders what business either group has in treating tics.

Daly proceeds to list five components of the "judgment that someone is mad", though he correctly points out that they do not necessarily imply madness. He expands on one of these components: "Instead of authoring his or her experiences in some or many situations in which the person desires or is expected to do so, the person's activities are determined in some other way." Psychoanalysts would say that this is true of all of us.

(2) The paper is ahistoric.

Certainly one can proffer a philosophical position without regard for history, but that seems poorly chosen in this case. I believe that a major problem with Daly's paper is that it is essentially ahistoric, although he briefly discusses history in footnotes. At various times in history (Thomas Willis, Jean Martin Charcot) psychiatry and neurology were essentially unified. There is a long history of unification and diversion. Members of both specialties wrote a great deal about the nature of sanity and insanity in the nineteenth century, with special emphasis on the role of "personality" in any theory of insanity – this was a matter of great debate for decades and separated European, British and American psychiatrists and neurologists. Daly equates problems of personality with madness, which is problematic. The psyche, however understood, consists of more than "personality". There is a very rich historical background to Daly's premise, and the paper would be improved by considering it.

(3) Sanity and the Mental Status Examination

Daly indicates that "passing" the exam is a measure of sanity. In fact, the mental status examination as he presents it, though commonly used, is not validated. Furthermore, this examination is notorious for "false negatives". Many highly and overtly para-

noid people, for example, perform well on this test.

Daly includes an abbreviated mental status examination from a synopsis of a textbook, as an appendix. Many of the "wrong" answers are listed by Daly as "marks of madness", but it should be evident to the reader that while wrong answers may indicate psychopathology, some can occur in the wake of unsettling events, trauma, loss, or even having a bad day: who among us does not demonstrate bad judgment on occasion?

One can agree or disagree with Daly's view that insanity/sanity demarcates psychiatry from neurology, but to base "sanity" on a very simplified set of questions seems jejeune. I recall an eighteen-year-old young woman whom I saw as an outpatient, the day after a visit to the Emergency Department. She had returned from school to find her mother dead. Her mother had been terminally ill, but no one expected her death to occur so quickly. The young woman managed extremely well, dealt with the medical examiner and funeral director, informed her father, who was divorced from the mother and living in another state, and opted to stay alone for the night after the body of her mother had been removed. As the night progressed, she felt frightened, overwhelmed and bereft. She went to the Emergency Department and asked to talk with someone. A resident talked to her and did a very thorough mental status examination. As she told me, "I wanted to talk to someone about the enormity of what had happened, and feeling bereft, and instead I got this idiot asking me how an apple and an orange are alike." A definition of psychiatry which excludes perspective and solace seems insufficient.

(4) Perspective, empathy and solace.

And this comment of the bereaved adolescent leads to my final criticism – that Daly's proposed definition of psychiatry seems to exclude perspective, empathy and solace. This is perhaps an unfair criticism, because he does mention "securing the health, or the organismic flourishing, of human persons". But this does not seem to be a major component of his definition, and it needs to be. Perspective, especially, is a *sine qua non* of good psychiatry, as are empathy and solace.

Psychiatry has a long history of "losing" patients and diseases to other specialties once etiologies are learned. Thus, tertiary syphilis joined the ranks of Infectious Disease, and myxedema madness those of Endocrinology. As I reviewed this history in a teaching session, a world-weary and cynical resident said, "Psychiatry takes care of the patients that no one else wants." (Now this assertion would make an interesting paper!)

But as psychiatry has "lost" diseases to other specialties, psychosomatic medicine, especially through the work of consultation-liaison psychiatrists, has claimed patients with all sorts of horrific diagnoses from all specialties. In contrast to Daly's view that disorders of sanity caused by medical conditions are not in the purview of psychiatry, many of our colleagues from other specialties embrace our expertise with these patients.

We need a continued discourse on what defines psychiatry. Efforts to define psychiatry never succeed. Daly has made a good effort.

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Sanity, Madness, and Personhood

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

I agree with Daly that thinking of psychiatric disorders, or mental disorders, as diseases of the brain, in the reductionistic way that that phrase is usually understood, misunderstands the nature of psychiatric illness and the goals of psychiatry as a clinical discipline. I further think that his paper makes a very interesting start at reconceptualizing psychiatry and psychiatric illness. I think, however, that despite his bold use of terms like "madness" and "sanity," that Daly does not follow his insights and arguments far enough. I suspect that this is because he is at great pains to be sure that we still see psychiatry as a medical specialty, whereas I think his own arguments point us towards the view that there are significant differences between psychiatry and other medical specialties. If we are to mount a true defense of psychiatry we must be able to acknowledge these differences while yet pointing to the factors that still have it make sense to say that psychiatry is a medical specialty, rather than say a matter of ethical counseling or social control. This is not merely a matter of theoretical concern. Daly writes that "If there are sound, practical, *medical* reasons why we should affirm that psychiatric disorders are diseases of the brain, it is reasonable to assert that psychiatry is neurology….The disciplines of neurology and psychiatry should be merged and departments of psychiatry become elements of neurological institutes. Colleges of medicine should merge clerkships in psychiatry with those in neurology" (Manuscript, p. 5). This has already begun to happen at some institutions.

Daly argues, I think correctly, that "In stories of madness, conduct in relation to others is replaced to some extent by mere behavior" (Manuscript, p.15). Mental illnesses are illnesses in which one's agency is interfered with. Daly, unfortunately, is not completely clear on this point, however, as he also talks about "alterations in human behavior and experience and associated organismic diminutions in agential capacity to which the neurologist *qua* neurologist attends and responds" (Manuscript, p. 11).

Daly writes as if this might just be the way the non-psychiatrist views things: "*The 'first diagnosis' is not made relative to the norms and findings regarding a person's brain or any of the other stuff of which persons are composed, nor of a state with a merely psychological or 'mental' designation.* Madness is predicated of persons as agents" (Manuscript, p.16). The biological psychiatrist might respond that this "first diagnosis" should not be the diagnosis the psychiatrist should be

concerned with. Patients might come to their internists complaining of shortness of breat. The internist would not accept that as the diagnosis. They would want to distinguish whether the shortness of breath was due to COPD or congestive heart failure, to pick two diagnoses out of the differential. What is it about madness that makes us have to stick to the level of the person, or agent?

Daly approaches the importance of this consideration when he writes that only human beings who are agents can be considered "mad," whereas "Any kind of human being, whether capable of authoring his conduct or not, can be diagnosed with a neurological condition" (Manuscript, p. 18). He does not follow this claim through, however, going on to say "the features we have so far identified of the judgment that someone is mad could, at least provisionally and in some cases, be assigned to someone who proves to have a neurological disorder" (manuscript, pp. 19-20). I think if the judgment of madness is made of someone who has a neurological disorder, to be consistent we ought to say that the judgment of "madness," of mental disorder, was made mistakenly. I am not sure whether Daly's use of the word " madness" does not contribute to leading him astray here.

He opposes the concept of "sanity" to that of "madness," and he defines sanity as "*that form of health or organismic capacity that a person enjoys when the elements of his personality are well enough founded, organized, developed, and integrated with one another, and with his knowledge and capacity to choose, so that a person is able in this way, by means of his actions, to secure his prudential interests*" (Manuscript, p. 24). He says it is by means of "the medical idea of sanity" that health and illness are established in psychiatry, "not by means of pointing to the results of an examination indicating that the criteria for the 'normal functioning of the nervous system' have been met" (Manuscript, p. 24). The psychiatrist who sees himself or herself as a type of neurologist would answer, I think, that this is only due to our current lack of knowledge, and with improved knowledge of the brain a neurological examination, perhaps undertaken with the aid of technology that we do not currently possess, would tell us whether the person had the capacities to "secure his prudential interests." What I think such a neurological examination might not be able to provide is an explanation of the choices, particularly normative choices, that a person is able to make. I have argued this point in a series of papers delivered at the International Network for Philosophy and Psychiatry conferences over the past few years. I do not have the space to outline these arguments here, but the basic argument is that freedom is central to our notion of personhood, and that freedom cannot be explained in neurological terms, even though our possession and exercize of freedom depends on our brains and not on any immaterial "mind' or "soul."

Daly goes on to argue that "Psychiatry interprets 'the organismic' as 'personality'; neurology constitutes 'the organismic' as the 'nervous system'" (Manuscript, p. 26). I think Daly wants to see it in this particular way so as to save psychiatry as a medical specialty from the encroachments of neurology on the one side and psychology on the other. I would say that psychiatry must conceive of its subjects as persons. Personality is part of what is needed to make a person, but personality is not equivalent to agency, to what can make human individuals persons. Rather than being "disorders of personality in the sense we have set forth" (Manuscript, p. 27), they are disorders of persons. We can preserve psychiatry as a medical specialty between neurology and psychology by recognizing that psychiatric illnesses are those that effect are personhood, and that such effects may arise from a complex interplay of biological and psychological factors. I think Daly would agree with this, as he writes "Human experience and behavior are composed in one way or another of what is in-born, i.e., of us but not determined by us, and what is acquired and, to some extent, determined by us" (Manuscript, p.27). That "one way or another" and "to some extent" are the placemarkers for some very difficult questions of philosophy and science, and the clearer we can be about those questions the better chance we have of answering them.

Thus when Daly states "it is not logically, linguistically, philosophically, or scientifically *necessary* that all psychiatric disorders are or will turn out to be 'diseases of the brain' any more than the marks and states of madness are *necessarily* just the end result of bad decisions or untoward interpersonal relations such as a lack of competent love or of domestic and social injustice" (Manuscript, p. 30) we might think that he is willing to consider different classes or categories of psychiatric disorder: diseases of the brain and diseases of psychological or social etiology. I think he would be truer to the core of his argument if he would say that all psychiatric illnesses are disorders of persons, with their biological and other aspects.

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How I learned to Stop Worrying and Love Psychiatric Kinds

Benjamin R. Lewis, M.D.

This ambitious paper by Robert Daly revisits the contested and oft-explored set of issues involved in characterizing precisely what kind of illness mental illness is. This exploration takes Daly from an in depth characterization of the practices of neurology and psychiatry, to the nature of health and illness more generally, to an attempt to limn the 'marks of madness' and, in so doing, give psychiatry a firm foothold in medical science. Daly's argument hinges on the assumption that the ontological status of these higher-order, person-level features of madness (as well as the specifically psychiatric epistemological methods involved, i.e. the mental status exam) suggest a fundamental irreducibility of the kinds of mental phenomena relevant to psychiatrists to brute facts about the brain (and

hence, per Daly, the province of neurologists). In the course of this argument, Daly confuses epistemological limitations of current psychiatric science for ontological distinctions between subject matter.

Daly is quite worried about a proposed equivalence between psychiatry and neurology (4): "If there are sound, practical, medical reasons why we should affirm that psychiatric disorders are diseases of the brain, it is reasonable to assert that psychiatry is neurology." While Daly's resistance to reductionism here (broadly construed) is well-intentioned, I struggle to feel the pull of this conflict. Psychiatry is not neurology. Otolaryngology is not gastroenterology. The divisions of health care provision are historically arbitrary and shaped pragmatically, largely based on the idiosyncrasies of service delivery. There need not be any deeper fact of the matter than this: as such it remains confusing why psychiatry has – historically and currently- struggled with a need to clearly, rigorously, even philosophically characterize the types of problems it deals with. The causal pathway of an anticholinergic delirium and its various manifestations can be explicated in fully *neurological* terms but there may be good reason (provided sufficient medical stability of course) for them to be managed on a psychiatry floor rather than a neurology floor (or internal medicine for that matter): namely, we're better and more practiced at managing certain behaviors. We don't need to fret extensively here as to whether the problem is 'psychiatric' or 'neurological'- indeed, an *ontological* distinction here between types is dubious without resorting to specious Cartesian dualism: an unfortunate fate that befalls Daly in this paper.

While Daly is correct to point out that higher-order mental phenomena (personality, beliefs, feelings) are unlikely to be entirely reducible and fully characterized using the language of neuroanatomy and neurobiology this does not then imply that these phenomena are not *brain* phenomena. What else could they possibly be? Pancreatic phenomena? Insofar as the species of illness we classify as *mental* in nature is heavily shaped by social, cultural, and political factors, these factors are mediated by the relevant organ in question: the brain. Being a good materialist, these factors play a role only insofar as they affect the brain. What am I missing here? We can analyze Deep Blue's chess prowess using the higher-order intentional language of 'belief', 'desire', and 'strategy' (i.e. Deep Blue knew that if I moved my knight to that square it would compromise the use of my queen) knowing full well that Deep Blue does not actually possess any of those so-called mental states, and we can do so quite successfully! In fact, this is what you do when you play a chess program (imagine having to predict the program's moves by analyzing the flow of current through logic gates and binary operations). No one would criticize you here for missing the boat in regards to what *really* is going on in your chess game. But of course, at heart, Deep Blue is simply using brute computational force to crunch numbers. Notably, if we want to understand why Deep Blue screws up in reproducible ways, we look a level lower: at the code, or potentially at the hardware (say, if he doesn't turn on).

Chemists don't fret extensively that the types of processes they work with are fundamentally produced by the underlying physics. And chemistry proves quite useful in understanding our universe. But when understanding a phenomenon proves difficult resorting to lower levels of explanation can be fruitful: particle physics certainly came in handy in characterizing Bose-Einstein condensates. True, when we switch levels we do switch subject matter in important ways. There may be good practical reasons to use terms like 'personality organization' or 'sanity' insofar as characterizing complexities of human behavior. And it is unlikely that we are going to find isomorphic neurological correlates for these higher-level phenomena. But to preclude attempting to understand *psychiatric* or *psychological* phenomena in terms of underlying brain phenomena risks continued isolation of psychiatry from the rest of the neurosciences.

In this regard, I'm not as reassured by Daly's confidence in the mental status exam as an epistemological tool in establishing what he describes as 'sanity' and its diminutions (hence psychiatric kinds). To begin with, Daly's depiction of 'sanity' is vague to the point that it is difficult to see how it could begin to accomplish his lofty goals here of justifying psychiatry as a 'medical specialty' and distinguishing 'psychiatric' content from 'neurological' content. Daly himself goes to great length to discuss the local variabilities in this assessment based on culture, historical epoch, personality: "everyone who is sane is sane in his or her way" (20). Peculiar Tolstoyan reversals aside, it is difficult to square this social constructedness with a proposed foundation of a medical science: indeed, it remains unclear why Daly does not avail himself here of evolutionary explanations per Wakefield as this might offer him some firmer ground to stand on. Insofar as it makes sense to evoke a coherent concept of 'sanity', the term likely refers to be a heterogeneous amalgamation of adaptive traits and behaviors that have been shaped by natural selection and that are produced and sustained by the brain. Certainly the nascent state of psychiatric science at this time necessitates using the gross phenomenological descriptions of the mental status exam to characterize these traits and their variabilities but it would be foolish to see this as a refined tool for grasping the causal underpinnings (and hence, uncovering possible medical interventions).

I recently had a patient on the inpatient unit of the psychiatric hospital where I work with adult-onset Tay Sachs. A rare variant of this disorder, the manifestations are predominantly psychiatric and present in early adulthood. In this case, the patient's presentation was mania with psychotic and catatonic features. Of course, on her Axis I could list "Mania due to Another Medical Condition". But is this *fundamentally* a different category from "Bipolar disorder, type I, current episode manic with psychotic and catatonic features"? These diagnostic categories remain simply phenomenologically descriptive (reflecting limits of current understanding of psychiatric illness). This patient's problem- although certainly complex and incompletely characterized – was fundamen-

tally neurological and due to the gradual and progressive accumulation of GM2 gangliosides in her neurons due to a genetically-driven defective hexosaminidase A. Does the fact that we have limited understanding of the (likely many and heterogeneous) neurological derrangments for every other case that we term "Bipolar Disorder, type I" imply that these are not 'neurological' problems?

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The Interpersonal Focus of Psychiatry

John Chardavoyne, M.D.

Dr. Robert Daly provides a cogent explication of his definition of mental illness and the rationale for why psychiatry is a medical specialty separate from neurology. In his paper, he defined health and ill-health with descriptions of the capacity for relations with others and dysfunctions in that capacity, respectively. I would like to expound the concept of the self in relation to others and how that is a primary focus of psychiatry. It is important to illuminate this vital aspect of psychiatry because it is a main reason why psychiatry differs from neurology and cannot be considered a subspecialty of neurology.

Psychiatric training involves learning Dr. George Engel's biopsychosocial model as a way to formulate patients' difficulties. Engel's ideas highlight the biological, psychological, and social influences on illness. (Engel, 1977) Psychiatrists train and practice by assessing and managing not only the potential biological contributors towards a psychiatric illness, they are attuned to the psychological and social contributors. Only in this way can a person's expected functioning within a particular culturally-sanctioned social group be evaluated to determine whether the person is able to function according to typical expectations in order to achieve the person's long term best interest. Since humans are social beings, functioning in the interpersonal realm is an important element of adaptive functioning and is a core aspect of dysfunction in psychiatric illness.

Many theorists and researchers have identified the capacity of forming and maintaining interpersonal relationships as an essential function of health. For example, John Bowlby, amongst other attachment theorists, demonstrated that the quality of early caregiving strongly contributed towards the infant's development of the capacity to form healthy relationships in adulthood. (Bowlby, 1969) This is theorized to occur through internal working models, which are belief systems, partially outside of an individual's awareness, about the self, others, and the world. Dysfunctional attachment styles have been correlated with mental illness, like borderline personality disorder. (Levy, 2005)

Moreover, Dr. Leonard Horowitz wrote a book on the Interpersonal Foundations of Psychopathology. (Horowitz, 2004) He proposes that interpersonal processes frequently underlie psychopathology. There are two broad categories of motives: the communal motive, which is the motive for affiliation; and the agentic motive, which is the motive for independence and autonomy. He examines different DSM-IV-TR diagnoses with the purpose of illuminating the interpersonal goals, ways to maintain self-image, frustration of goals, and the interpersonal processes that contribute towards psychopathology. Along these lines, Dr. Sidney Blatt has written about two broad personality types, interpersonal relatedness and self-definition, that can contribute towards depression when they are dysfunctional. (Blatt, 1992). Alternatively, Otto Kernberg has theorized about unconscious representations of self and others that contribute toward the development of borderline personality disorder. (Kernberg, 1975). Based on his theory, transference-focused psychotherapy has become an evidence-based treatment for borderline personality disorder. (Clarkin et al, 2006)

These various examples illustrate the interpersonal contributors towards the development and perpetuation of psychopathology. Although a person may approach a psychiatrist with subjective symptoms or distressing behaviors, with a comprehensive assessment the interpersonal factors and how the person views the self in relation towards others become important elements of the formulation and treatment. The paramount importance of interpersonal processes explains the research finding that treatment outcome is highly correlated with treatment alliance. Regardless of whether the treatment relationship is the focus of treatment, the treatment relationship is integral for the patient to recover.

In conclusion, psychiatrists pay attention to elements of biological dysfunction as well as to dysfunction in psychological and cultural/social / spiritual domains. Daly describes how psychiatrists consider the capacity for interpersonal functioning, although does not elaborate on this important aspect of psychiatric practice. A key feature of formulating psychiatric psychopathology is to understand the way the person views the self in relation to others and the world. This information is communicated through verbal communication, nonverbal communication, and how the psychiatrist feels towards the patient. With this information, the psychiatrist can help the person to become an agent of choice again with increased capacity to adapt to the person's social environment in order to pursue what is in the person's long-term best interest.

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'Fuzzy Boundaries', or Why Science Really Is a Matter of Faith

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

Initial Considerations

I would like to start this response by thanking Dr. Daly, aside from his exceedingly thoughtful and insightful consideration of the less than 'fuzzy boundary' between psychiatry and neurology, for calling attention, thankfully with less flare for cliché than myself, or Steven Pinker – from whom I borrow the appropriate, if exceedingly unoriginal quotation – to the new elephant in the anti-psychiatrist's waiting room. That is – and to be sure this is my interpretation – in the aftermath of the two late great science fiction writers-cum-Hollywood/Wall Street-evangelical-opportunists, L. Ron Hubbard and Thomas Szasz, the more recent, and much more dangerous, assault on psychiatry has come not from disgruntled hacks but from the psychiatrist-cum-quasi-neurologist lobby of the American Psychiatric Association. While it is true that no one has yet written a book titled *Proust Was a Psychiatrist* (Lehrer, 2007), *Brain on Fire* is a bestseller, describing one acutely psychotic woman's desperate clawing free of the evil clutches of psychiatry into the warm and caring bosom of neurology (Cahalan, 2012). This is not to further knock psychiatry as inept, but to further demonstrate the 21st century lay public's greater, if paradoxical, confidence in 'hard science' – the public's actual desire for the much criticized "medical gaze" of the structuralists – and psychiatry's (along with the rest of post-structuralist medicine's) 21st century willingness to react to public outcry. As Dr. Daly demonstrates, however, psychiatry is at least partially, if not near-wholly, social science. For those of us who come from humanities backgrounds this defensive posturing for respectability is not a new fight. Sociologists and psychologists have been crunching numbers now for decades in efforts to gain statistical significance, and only recently has the notion of 'evidence-based' social programs come to the fore in policy-making. But lest we forget, modern psychiatry was born of neurology's inability to manage 'madness' effectively, and there is little clamor from neurology to re-expand its scope to encompass psychiatry (Bynum, 1985, pp. 85-102; Rose, 1999). The first specialty hospitals were in fact facilities dedicated to the containment and treatment of madness, and the arguably oldest neurology journal extant, Oxford's *Brain*, began life as the *Reports of the West Riding Asylum* before forsaking madness to become *Brain* in 1878 (Rose, 1999). (Might we not see an historical parallel in our own time if and when the R-DoC-tors splinter off and create their own new field, psycho-neurology?) What is spectacularly overlooked, however, is the fact that psychiatry – keeping in mind that a rose by any other name – dominated all of medicine until the 19th century. Cures, after all, have only been around for a little more than a century and a half (if you count vaccines and public hygiene measures; if not, then for about a century), and medicine prior to that, other than the entirely distinct field of barbery/surgery, was a matter of managing distress and providing supportive care. Call it what you will – fatalism, despair, religion – it all came down to psych at the bedside (Bliss, 2010). (My own father, a podiatrist, used to advise us, his kids, that if we were to choose a career in medicine, first to go pharmacy school, but if it had to be medical school then to pursue either neurology or psychiatry. When I finally asked him why, he answered that the liability in both was much lower than other medical specialties as these are the only two fields in which there are still no cures.)

Psychiatric Disorders Are Disorders of the Brain

Indeed, following Dr. Daly's reasoning, there is no arguing the point that if psychiatric disorders become "brain" disorders, then by definition neurology will have won the day. To some extent this has already occurred. Experience, if not necessarily meta-analysis, tells us that most neurologists do not hesitate to treat most psychiatric disorders (or at least 'give it a try'), nor do many primary care physicians for that matter. This is obviously a one-way street, as experience again tells us that few psychiatrists are comfortable treating primary neurologic or other medical disorders. To return, regrettably, to Pinker, however, there are yet 'fuzzy boundaries' wherein psychiatry shares the burden with other specialties, such as dementia, delirium, autism, substance intoxications and withdrawals. Whether these qualify as states of 'madness', according to Dr. Daly, is questionable, as these do not necessarily indicate disordered personalities *per se*. The interesting, if overlooked, point in this regard is that patients, people, seem to hear it differently when a psychiatrist diagnoses delirium than when a critical care specialist does, or when a psychiatrist diagnoses dementia than when a neurologist does. It is not a profound statement that people fear psychiatry, that people fear psychiatry because people fear madness, probably much more so than cancer (House of Commons, 2009-10). Madness after all still bears the legacy of the asylum, of the literature and popular culture of the Enlightenment.

Dementophobia, fear of losing one's mind, is rampant in the Gothic horror literature of the late 18th and 19th centuries, into the decadent literature of the late 19th and early 20th centuries. It became less of a popular theme as medical 'science' progressed, alongside its pseudoscience equivalent, psychoanalysis, and with them both, the hope for a 'cure'. Historically, madness has

existed at least since the Mesopotamians first put stylus to clay, and the Ancients never doubted its existence (I will return to this later). It was really the Enlightenment, with its unwavering faith in reason, that brought about the profound fear of madness in Western culture. Foucault obviously most famously discussed the implications of the Age of Reason, the opening of the mind suddenly to the whims of the id, and the confusion engendered thereby as to reason and unreason, unreason and madness. From an historical perspective to conclude then that 'madness' was a construct of this time period is clearly nonsensical, as madness, by this very logic, would have predated 'reason' by thousands and more years. But the point is well taken that a fine line, a 'fuzzy boundary', may sometimes exist between unreason and madness. (Witness Descartes' logical, if pre-phenomenological, contortions via dream states and, of all things, an evil demon.)

Foucault's interpretation of confinement as a societal means of identifying the 'sick' from the 'not sick' – from the lazarettoes, to the quarantines of the black plague, and eventually to the asylums – invests psychiatrists especially, in the latter part of his history, with an omnipotence heretofore unheard of in the medical literature (Foucault, 2006). In other words, the psychiatrists (again, a physician by any other name…) were the first to jump on board the specialty bandwagon, the first physicians to usurp this special power to confine people, whether for the purposes of coercive treatment or not, whether the treatment was truly 'moral' or not. (Foucault, 2008). Psychiatrists still wield this power, and more dangerously so, to Foucault, because they aggressively avoid the 'medical gaze' that characterizes the rest of medicine (whether by sitting behind the patient, or by their perceived empathy), thereby colluding insidiously with the patient.

For our purposes here, the point is, despite Foucault and the other anti-humanists, people in the 21st century, and especially so in the post-Enlightenment West, have maintained this well-wrought fear of losing the ability to act as their own agents. They fear losing their dignity above all (Murray, 2004). (How many elderly patients have we seen who tremble in dread at the outset of what would otherwise appear to be a relatively benign mini-mental status examination?) To speak more plainly than Dr. Daly, a neurologist represents hope. A neurologist represents the possibility that 'I am not mad', that there is a pathophysiologic reason that I am no longer capable of acting on my own behalf. A neurologist represents medicine as divorced from the environment. The questions are less penetrating, less discomforting. Your wife's affairs in the face of your impotence are of little importance, as are the facts that you are a poorly employed single parent with two autistic children in the house about to be evicted. The neurologist as a human being may care, but as a scientist, as a physician, he/she does not, and it is precisely that medical ambivalence, that 'medical gaze' that many people find to be in fact a paternalistic (or maternalistic – choose your semantics) relief. The psychiatrist, say, as a referral from the neurologist, represents hopelessness. It means the scientific world has given up; it means worst fears are confirmed. 'I am crazy', 'I am mad', 'I no longer have control'. This extends even to treatment. An antipsychotic prescribed by a neurologist or a critical care physician is somehow an easier pill to swallow for most people than when prescribed by a psychiatrist. All of this is to agree with Dr. Daly on his assessment of the field as no longer being of two minds, but three: biologic, psychodynamic, and now neurologic. (The so-called 'Recovery Movement' has been preaching for years to minimize the role of the psychiatrist to that of neuropsychopharmacologic consultant in the care of the persistently and seriously mentally ill. [Davidson, et al, 2006)

The Nature of the Question

That all said by way of introduction, it is with Dr. Daly's conceptualization of the 'nature of the question' – whether psychiatry should be recognized and reordered as neurology – that I offer more critical commentary. I turn first to his mention, his assumption really, that the 'philosophy of medicine' has provided the foundational currency on which his reflections will be based. This is problematic in that, although much has been written and argued regarding the philosophy of psychiatry, especially in recent years (Fulford et al, 2006), 'controlling' for the over-representation of the recent ethics literature, surprisingly little, since the Antique Greeks and Middle Age Arabs, has actually been written about the philosophy of medicine (Downie, 2005). Indeed medicine has somehow found itself, here in the Age of Cures, exempt from the philosophic rigor of the philosophy of science, and even of social science. There are several issues in this regard, and they bear noting as Dr. Daly accepts the premise of a 'good health' as opposed to 'ill-health' in making his claims as to psychiatric well-being, and as both psychiatry and the rest of medicine have committed to these 'core values' at present. Expanding upon Downie's brief but comprehensive critique of the philosophy of medicine, foremost, in this age of 'evidence-based medicine', is the problematic nature of the 'evidence' (and it should be clear that this is not the same thing as 'science-based' medicine, as is often presumed). It does not take a clinician or philosopher to see that mega-industrial complexes, arguably the entire 'health care system', have been built around the statistical correlations of treatments with percentage 'success rates' based on arbitrary endpoints, otherwise known as the randomized controlled trial (RCT), also referred to euphemistically as the 'gold standard' of 'evidence'. But especially in psychiatry, where co-morbidity is the rule, and acknowledging – where researchers do not – that except under exceptional circumstances there is no 'controlling' for environment, the fact that the test 'patients' in these studies are typically healthy, if cash-strapped, 'volunteers' who (most) often are not representative of actual patient populations makes this 'evidence' suspect at best. (I also would refer readers to a recent Mayo Clinic report that looked at all the original articles published in the *New England Journal of Medicine* between 2001 and 2010, and determined that 363 of these were tests of current 'standard of

care'. Of these, 40% of the published studies found current practice to be ineffective, 38% re-affirmed current practice, and 21% were inconclusive. Gold standard? [Prasad, et al, 2013]. It is also well to keep in mind that the Helsinki Accords are being revised yet again this year, with the US poised to remain the only First World country to refuse steadfastly [citing legal restrictions unique to the US] to sign it. The implications for the conducting of research in Third World countries are enormous. The 'equipoise' justification for conducting experiments on impoverished individuals is a 'whole 'nuther paper'. [Elliott, 2010])

The definition of evidence, again the 21st century premise of medicine, is further problematic in that the 'evidence' used to make a diagnosis is clearly different from the 'evidence' as developed through an RCT, as is the 'evidence' before one's eyes in any given clinical situation (typically, paradoxically, regarded as the weakest level of evidence on the so-called 'evidence hierarchy'). And adding even more complication is the often hushed observation that the same 'evidence' collected for medical and insurance determination purposes is often politically taboo in social science (i.e. possible racial/ethnic/gender contributions to various states of affairs), making effective psychosocial research near impossible. (There is also the inherent problem with evidence in that such is based on rationality, with an understood premise that evidence for or against something will convince a rational human being…) Qualitative evidence is perhaps even more concerning in that it is created mostly through the use of questionnaires that often inquire into abstractions, such as 'quality of life years'. Also, it is subject to the same evaluative and logical contortions as the social sciences when 'interpreting' evidence, re: ethnic, family, gender, and socioeconomic studies. Other, more recently acknowledged, if yet unresolved, problems that fall under the purview of 'philosophy of medicine' are those of personal identity versus genotype (in which case we can wave a heartfelt sayonara both to neurology and psychiatry), the acceptable limits of medicine (is there such a thing as 'super-health'? what of cosmetic medicine, including the latest in so-called 'neuro-enhancement'?), and of course the biggest philosophic problem in medicine, let alone all the über-hype regarding the phenomenology of DSM, and perhaps most important with regard to Dr. Daly's attempts to classify good health from bad, is that the rest of medicine hardly pauses to ask itself, 'What is disease?', let alone, 'What is good health?' (As early as the 1940's Horkheimer and Adorno were critical of what they termed "advanced institutionalization" in their description of the then current trend in medicine. They describe "the doctor" as an agent of "business and its hierarchy vis-à-vis the patient", "an agent of big business against consumers". This has not always been the case, according to the authors, as before the rise of specialties, "The profession of family doctor may have been more innocuous, but that is in decline." This critique is interestingly used as the illustration of the natural "contradiction" that the aim of philosophy [since the Enlightenment, or Age of Reason] is to "simply reaffirm the prevalent rules". Its context is a 'debate' between 'interlocutors A and B' in which 'A' tries to point out the 'logical flaw' in 'B''s expressed distaste for the field of medicine, i.e. the relativity of logic depending upon whose service it is being utilized. Or, in other words, the 'logical' conclusion that stems from such a debate, 'Would you prefer a world with no doctors?' [Horkheimer and Adorno, 2002, pp. 197-199]). All this is to say that using an underlying premise of a philosophy of medicine upon which to build an argument is more tenuous even than utilizing a philosophy of psychiatry.

Health, Ill-Health, and Medicine

Whereas "sanity" has then to some extent been studied, if only dimensionally from legal, social, and medical perspectives, the spectrum of "health" clearly remains ill-defined. I agree with Dr. Daly that mental illness is no less a problem of health. And although the example from Plato in the *Phaedrus* is duly noted, it should also be pointed out, not as 'buzz-kill', but as reflection of the present, and appropriate in a commentary on the 'origins' of psychiatry, just what having a disease 'of divine origin' would have likely meant in practical terms in ancient times. In the pre-Greek literature, that is the Mesopotamian and Egyptian sources (and to a much lesser extent the much later Western Semitic) – cultures with a fair amount of extant medical literature – there is certainly a 'divine element' associated with madness and epilepsy both (with yet another 'fuzzy boundary' distinguishing the two illnesses, and yet another 'fuzzy boundary' distinguishing the natural from the supernatural in general in a polytheistic society), but madness and epilepsy both marked their unfortunate victims. To be possessed of a god or demon was no blessing (one is reminded of the Ottoman practice of branding especially loyal slaves as 'reward' for service), and the madman and epileptic both were shunned, in some instances 'put out of their misery' as prescribed by the healers of the day (Stol, 1993). Among the Western Semites, to present more familiar examples, the Hebrew Bible and New Testament both bear witness to any number of 'mad' or 'dangerous' prophets hearing voices who, though often feared or revered, and at times even tolerated, were certainly not integrated into society, and quite often persecuted, even executed. Even among the Greeks, 'lunacy' was initially often regarded as a possession by the gods, but one should not lose sight of the context of Greek divinity (ambivalent gods; stupid gods; very flawed gods). I have written previously on the development of the physician from priest-healer in the Near East to philosopher-healer under the increasingly 'rational' Greeks and later Romans (Martin, 2012). But what is most germane to this discussion is that there was no doubting the existence of madness among ancient cultures (these were empirical people, after all, and it is was hard, despite the 'evidence hierarchy', to dispute the evidence before their own eyes), with epilepsy subsumed under this classification, and medicine arguably developed as increasingly 'rational' response to the

inadequacy of religious intervention, especially so in the dramatic face of madness. Ancient definitions of 'good health' were far more concerned with a 'sound mind' than sound body. (For millennia the mind was believed to be situated in the belly, and maintaining good digestive health was often the key to maintaining good mental health, and therefore good overall health.) One indeed may have been 'blessed' with the 'divine madness', but this was a blessing most would have likely preferred to do without. (Witness as well any number of Classical protagonists: Kassandra, Medea, Oedipus, Ajax. I would add, too, most pre-Greek 'heroes', by thousands of years, such as Gilgamesh and Utnapishtum. Odysseus himself, the most perfectly realized depiction of psychological complexity in ancient literature, and arguably the literary bridge into modernity, when confronted with the choice to become immortal – that is, to lose his humanity – famously shunned it.) Madness may have bestowed a certain awe upon its sufferer, not so unlike today, but it is also well to keep in mind the natural course of severe madness, without recourse to confinement. (And then there is the consequence of 'cure', to alleviate the burden of divinity, so to speak, especially among the current celebrity of 'creativity', the Hollywood-cachet of just 'a touch of madness'.)

Neurology and Psychiatry as Specialties of Medicine

Returning to the here and now, specifically with regard to neurology versus psychiatry, the difference between the two would seem to be the difference between pathophysiology and pathology. Sanity, in neurologic terms, is intimately tied to the health of the nervous system. However, as Dr. Daly points out, it is not necessary that a person with a neurologic disorder not be sane. It is very interesting that Dr. Daly's description then of psychiatry takes on a decidedly more literary quality as he searches for 'themes' among the 'stories' of psychiatric patients that help distinguish madness from sanity. Conceptually, that 'psychiatrists do not originate psychiatry' would imply the opposite, that psychiatry originates psychiatrists, that *a priori* there exists mental illness that will sooner or later require the attention of a specialist. In other words, that patients create madness. He proposes a 'pre-psychiatry' phase of illness, similar to a prodromal period, in which society starts to take notice of changes in the individual. And although he does not state it explicitly, there is a remarkable insight here regarding the difference between psychiatry and the rest of systemic medicine, a difference manipulated variously according to agenda. Everyone at some point has felt 'unwell' in the course of their lives, but it is not likely that all oncologists have felt 'cancerous', or that all surgeons have felt obstructed in their small bowels, or that all gynecologists have experienced menstrual discomfort. It is highly probable, however, that most psychiatrists, as human beings, have specifically suffered from some variation of 'mental disorder' at some point in their lives. Everyone has at one point or another been depressed, been anxious, been sleepless, been bereft. Everyone has been euphoric, obsessive, compulsive. To misquote *Psycho's* famous protagonist, Norman Bates, "We all go a little crazy…sometimes." Many have contemplated, however briefly, and without ending up in psychiatric units, suicide or homicide as possible solutions. Many have been paranoid, with or without reason, and most have been intoxicated on one substance or another. As contrast, my having felt unwell at some point due to a viral illness provides me little insight into the suffering of a cancer or a trauma patient, or provides me little insight into the suffering of an epileptic or a Parkinson's patient. Everyone has an opinion on psychiatry based on shared experience. Witness the noteworthy fact that psychiatry is by far the most portrayed medical specialty on film (in Hollywood anyway, even by profession of main character, only modestly less so than cowboys, 404 versus 491, according to a *Scotsman* review in July 17, 2007 – it may not be topic *du jour* among the literati, but among the movie-going crowd Proust appears untranslatable). Certainly, as described above, we are treading on significantly insignificant evidence here, that before our eyes, and so how then, according to Dr. Daly, is the psychiatric patient 'created'?

The First Diagnosis, and Five Features of the Judgment of Madness

Madness is first diagnosed, 'judged', in lay terms. Essentially here is a phenomenologic description of psycho-pathologic states, marked by the 'proto-patient' losing his/her ability to further author his/her own 'narrative'. These are sweeping statements, assessing psycho-pathologic states, but how does this differ from the conclusions of a neurologic assessment? The key, according to Dr. Daly, is 'agential performance', the ability to perform adequately in compliance with the then and now operating social norms. To me this is a much more profound argument than the logically sound conclusion drawn by Dr. Daly that neurologically afflicted persons are not necessarily agentially afflicted. In other words, neurologic and psychiatric disorder can co-exist. But the statement that madness is relative is likely closer to the truth; that is, that madness is not diagnosed based on scales of sanity, but rather on the ability to function relative to societal expectations. The implication then is that madness is more of a social disease, especially if it is true that the initial diagnosis is a 'lay' diagnosis. (And may explain why Freud himself became less a neurologist-cum-psychiatrist and more a social scientist-cum-anthropologist in his latter years.)

Enter Psychiatry, and What the Examination by the Psychiatrist Requires

Can we then distinguish psychiatry as a medical specialty? This is where things become a little confusing. Dr. Daly puts forth the key question as, "… *is there a concept of health (largely tacit) operative in society which informs credible judgments that someone is mad and by which we can distinguish psychiatry as a medical specialty*?" (Daly's italics) Dr. Daly answers his own question somewhat affirmatively, "I believe there is." This puts the onus for both psychopathology and its diagnosis on society. The second part of his key two-part

question continues, "*Do we find this same concept operative in the practices and cultures of the psychiatrist, that is, a foundational mode of good organismic ordering (i.e. of a kind of good health) that is different from 'the functional integrity of the nervous system' by which we have identified the sort of good health that is sought by the neurologist*?" (Again, Dr. Daly's italics.) Again, Daly answers in the somewhat affirmative, "I believe we do." In reflecting upon my own response to this question I could not help but be reminded of neurologist Kurt Goldstein's seminal work, *The Organism*, first published in 1934 as conclusions drawn from years of experience treating the especially grievously wounded World War I veterans. Dr. Goldstein took vehement issue with the separation of mind from body, defining 'disease' as an 'organism's' disturbed relationship with its environment, whether physical or mental. Recovery is then logically described as the 'organism's' successful adaptation to its new environment, again whether physical or mental. Written at a time when neurology was first asserting itself as a distinct specialty this would seem to be an argument for subsuming psychiatry under neurology. But really, the entire book makes the case for holism in general, and I believe Dr. Daly's assertions remain valid in this context: integrating systems does not negate the existence of these systems as discrete entities (Goldstein, 1995).

Dr. Daly, to explain, turns his attention to the mental status exam, as unique and fundamentally different from the neurologic exam, and thus demonstrating a functional integrity of the 'psychiatric system' as distinct from that of the 'nervous system'. In keeping with the suggestion of mental illness as social disease this would seem to place the psychiatrist in the position of societal arbiter, as "… identification of the marks of madness elicited by this exam must arise by way of contrasting the presence of these marks with tacit knowledge of what is normally present in the activities and experience of persons who are not mad". There then follows a sort of 'capacity manifesto' meant to help people 'pass' the mental status exam. This is an ambiguous list designed to test perception, cognition, memory, emotion, fund of knowledge, propensity toward or against certain behaviors that when taken together will enable the psychiatrist to "evaluate the personality of an individual in order to determine if his capacities of individuality (or personality) are sufficient to enable that person, in and through his activities, to secure his prudential interests". More importantly is the furthering of this concept in order to encompass a view of 'sanity' as good mental health, such that "…these capacities, when successfully and durably integrated and operative in the life of a person, count as criteria for a kind of human health". Dr. Daly then defines 'sanity' explicitly as "that form of health or organismic capacity that a person enjoys when the elements of his personality are well enough founded, organized, developed, and integrated with one another, and with his knowledge and capacity to choose, so that a person is able in this way, by means of his actions, to secure his prudential interests". He refers to this as the "medical idea of sanity", as opposed to the "normal functioning of the nervous system". In other words, the 'psychiatric system' would apparently be that system, that part of the human organism that interacts with the greater world at large. And thus the dimunition of sanity would result in pathology, or states of madness.

Of greater interest in this regard is Dr. Daly's description of both madness and sanity as "open-textured", or subjective, again pointing to psychiatry as a social science. What comprises madness here and now, might not then be madness a hundred years from now. Disorders of the nervous system, after all, would be expected to present the same across cultures and across historical epochs. But other than some minor DSM diagnoses such as paraphilias, and addictions to newer substances, I would emphatically disagree with Dr. Daly on this count. Madness is madness, so to speak, and historically, as has been noted, with minor variations, there has always been clear recognition of madness, with consistent symptomatology, dating from the earliest written records. In fact, Dr. Daly's return to 'madness' and 'sanity' as measures of ill-health and good health hearken to eras in which this was just such the case. Madness was arguably the 'disease' that most declared itself for millennia, the impetus for the development first of the shaman, or healer-priest, then for the philosopher-physician of the Greco-Roman periods. There are references to madness in the earliest extant medical texts, across cultures, and it is almost certain that neurologic disease was subsumed more under this category. The Enlightenment, of course, saw the birth of the more 'modern' physician, divorced from religion and philosophy both, a keen observer of the natural course of disease and prognosis. The Enlightenment, as we have noted, also heralded the age of critical self-reflection, the 'opening of the mind', so to speak, a primarily Western phenomenon, that in and of itself has been the likely impetus for the ever increasing amount of melancholia, anxiety, and suicide in the Western world ever since. (And little wonder at the fundamentalist appeal more recently of 'closing the mind' once again.) Psychiatry has fallen victim to this same intellectual 'trap'. It is the only field of medicine that has subjected itself to self-reflection and scrutiny, been racked by self-doubt such that its own practitioners have tried to 'kill it off'. Can one even imagine an anti-cardiology movement, or anti-neurology movement?

Dr. Daly has the differences as "neurology constitutes the 'the organismic' as the 'nervous system'" while "psychiatry interprets 'the organismic' as 'personality'", with psychiatry then charged with restoring and maintaining the health of the personality. One might reasonably extend this line of thinking to conceive of psychiatric disorders then as personality disorders, as the outward manifestation of the nervous system. But the question then remains: if one were to somehow "fix" a disordered nervous system does that imply that a 'broken' personality might then

be "fixed"? Clearly, empirically, this is not the case. There is no shortage of psychiatric patients with co-morbid neurologic conditions otherwise well-managed, and there are no shortage of referrals to psychiatry from neurology.

Neurology, Personality, and the Neurosciences; and Psychiatry, the Nervous System, and the Neuro-sciences

The 'integrity of the nervous system' is here pitted against 'life'. Life interferes with science, and thus creates problems for the neuroscientist. What can the nervous system then tell the psychiatrist about a disordered personality? To my own dismay I suggest again looking to the 'fuzzy boundaries', to the place, medically, where neurology and psychiatry are wedded, that is, to the somatoform disorders (perhaps better categorized, in nostalgic DSM-IV-TR fashion, as 'medical disorders secondary to a general psychiatric condition'). This psychiatric category is especially noteworthy in that a distinct but sizable subset of patients manifests very similar symptomatology, without conspiracy, and that the key similarity among these is the, willful or not, production of neurologic impairment. (Freud's old 'hysterics', the very inspiration for the creation of the field of modern psychiatry.) Granted, my empirical view from the ivory tower is a bit skewed as I work primarily in a major academic children's hospital where hysteria is very much alive and well, and neurology and psychiatry often work as a team (and where, by the way, no department is more appreciative of psychiatry than neurology). Regardless of the prevalence, however, clearly somatoform patients are among the most disordered personalities, and the biggest challenge facing the clinician, distributed equally among neurologists and psychiatrists, is convincing the patient that he or she has a primary psychiatric condition. These are the cases that humble the neuroscientist, typically, into accepting the role of the psychiatrist. (Of course new discoveries, such as anti-NMDA encephalitis and PANDAS, though exceedingly rare, have created some 'psycho-biologic cowboys' who would have us all believe that antibiotics and IVIG will cure all psychiatric disorders. Mitochondrial disease, another exceedingly rare and terrible category, has likewise and unfortunately created a cottage academic industry on equivocal lab tests [pandering to the so-called 'mitochondriacs'], representing another, more recent, subclass of somatoform patients.)

And as for self-disparaging psychiatrists who do wish to hold on to the fantasy that all psychiatry will one day be revealed to be brain disease, genetic disorder, or immune system malfunction, perhaps acknowledging the collective denial over the past decade is in order. That is, the fact that despite billions of dollars poured into research to discover the molecular and genetic bases of psychiatric disorder about the best that can be said is that these disorders have now been proven to be 'multifactorial'. Not one meaningful new treatment has emerged. This is not meant to disparage the well-meaning researchers, but to lend support to Dr. Daly's thesis that psychiatric disorders are indeed social disorders. Witness the id currently in all its exposed glory. Mass hysteria is alive and well, cyber-bullying continues to enhance and spread the scope of suicide, and technology, as currently constituted, would seem to enhance selection of autistic and limited attentional traits. Borderline and antisocial personality are the Hollywood, Madison Avenue, and Wall Street 'ideal-types', and mass murder, a two-way street between murderer and media, is alive and well. There is little arguing with Baudrillard's conclusion that 'evil' – that is, anything that disrupts "the flow of systems"; that is, plainly speaking, corporate psychopathy – has won the day; that 'evil' has been media-exposed in all its decrepit glory, and no longer hides, because it doesn't have to (Baudrillard, 2009). An exposed id, and hence an explosion of mental illness worldwide. But psychiatric 'diseases' cannot be isolated from their environment except, somewhat ironically, by returning to confinement, a veritable 'crime against humanity' in these gun-waving, shoot-the-messenger times.

What is most intriguing, however, is the possibility of extending Dr. Daly's paradigm to the rest of medicine, especially in the context of a 'health care crisis'. How much of 'good health' and 'ill-health' are determined by environment? Are strokes and small bowel obstructions the results of clots and gastroparesis? Or are they the results of the inability to eat well as determined by one's socio-economic situation? Again, the 'Enlightenment' has dawned on psychiatry. Psychiatry encompasses everything. The movement to compress psychiatry into a subcategory of neurology represents a very immature regressive stance among those who would deny their own existence.

Dr. Daly sums it up best when he says that psychiatry must attend to "findings of a wide and diverse set of sciences and humanities". Psychiatry is different from the rest of medicine in that way. Psychiatrists must be better able to live with 'failure', they must be better able to manage other specialists in the face of difficult and unpredictable patients; they must be comfortable as the last resort. Medicine needs psychiatry for that reason. Neurology especially does. One definition of psychiatric disorder indeed might be 'what remains when a neurologist becomes frustrated'. The buck stops at the psych ward, and this may indeed account for why psych patients receive so few get well cards.

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Response to Commentaries

Robert Daly, M.D.

Preliminary Notes to Readers

Readers will recall that I intend the term "mental disorder" to denote the generic medical meaning of a family of terms: mental illness, mental disorder, mad, mental disease, psychiatric disorder, crazy etc. My reason for doing so is found in the footnote (*) at the end of "Summary," the initial section of my paper.

I thank the commentators for reading my paper and for writing diverse and engaging responses to that text.

In my reply to each, I limit my remarks to the writer's comments that pertain to the method and content of "Sanity and the Origins of Psychiatry." In these replies, I seek to avoid rewriting that text, and to refrain from engaging with passages in the commentaries that, in my view, do not pertain to my paper - though these comments may be of interest in other ways.

Even so, 'every reading is a rewriting.'

Reply to Professor v.d. Luft

I thank Prof. Luft for his informed and informing comments.

My understanding of "Sanity and the Origins of Psychiatry" is enriched by his scholarship and by the placement of my views in wider cultural contexts than the paper itself exhibits. Special thanks for his comments on (1) Jaspers and the German language of sanity, (2) his familiarity with previous papers of mine that bear on the questions I here consider, (3) his creative approach to the very difficult topic of 'sanity' concerning which so little is known, and (4) introducing me to the work of Jennifer Booth and Edward Pols.

I encourage readers of The Bulletin to learn from his commentary, as I did.

Response to Professor Bluhm

The aim of my paper is to identify, within medicine and under the penumbra of the health of persons, those differentiating and organizing ideas in terms of which we legitimate psychiatry as a distinct medical specialty. With that aim in mind, I address three matters raised by Professor Bluhm:

i. "serious illness of any sort affects agency;"

ii. "the ill-health that Daly describes is different only in degree, not in kind, from ill-health caused by "physical disorders;"

iii. the idea that "psychiatrists focus on the patient as a person and aim to restore the person - rather than the brain - to a state of health;" and ". . . psychiatrists are concerned with the whole person."

i. States of ill-health, by definition, impair or threaten to impair the health of persons as agents. I agree.

When confronted with ill-health of any sort, all physicians share or should share, a general intention to restore the health of persons. 'Health' is here understood as the organismic foundations of the capacity of a person to conduct himself as a human agent with respect to securing his prudential interests. In this very general sense, physicians are, or should be, alike.

ii. But this general principle needs refinement if we are to understand psychiatry as a historically-emergent, distinct medical specialty insofar as it *differs* from neurology and other specialties.

It is commonly accepted in the lexicon and grammar of medicine, and even in the light of the changing social organization of medicine, that ill-health is manifested in different ways. An illness is a different kind of ill-health than an injury. A disabling pain is a different kind of ill-health than a mental disorder. There are, in turn, kinds and degrees of illness, injury, pain, and mental disorder.

In the course of the history of medicine, some of these different forms of ill-health have given rise to specialties that have, as their distinguishing principle, the fact that they attend to persons with one or another of these forms of ill-health. Psychiatrists and neurologists, as specialists, attend to different forms of ill-health because these different forms of ill-health require different modes of practical expertise. In keeping with their work, different specialists employ different, subsidiary, senses and concepts of health and ill-health. (See my text, Part One, "Health, Ill-Health, and Medicine.")

But according to Professor Bluhm my effort fails, or almost fails, to articulate a principle that would clearly distinguish psychiatry from other specialties.

It is helpful to note, as she does, that of the five features of the judgment that someone "has a mental disorder," features 1,4, and 5 - *taken in their simplest iteration and in isolation* from features 2 and 3 - signal ill-health, not a particular kind of ill-health. Features 2 and 3 point most distinctly to a "mental disorder," and color, with a more or less distinct hue peculiar to mental disorders, our experience of features 1,4, and 5. But on Bluhm's reading, features 2 and 3 do not do this in a compelling way. She believes that Part Two of the text, "The First Diagnosis," simply shows that mental disorders constitute ill-health in the same sense as do all other organismic disorders of human persons. On this point, Professor Bluhm and I disagree.

Judgments affirming that persons suffering from a mental disorder reveal that all 5 features of such judgments are related to and combined with one another in complex ways on the different occasions. Further discussions in my text show that such judgments suppose norms of sanity. These passages add to the reader's understanding of how these five features are to be understood and why it is that mental disorders are, in fact, distinguished from other kinds of ill-health.

So I agree that mental disorders "affect agency" and are in that way like other kinds of ill-health. However, this insight does not, in my view, answer or make irrelevant such questions as the following: How and what do we know when we judge that someone has or is suffering from a mental disorder? In what way does a mental disorders affect agency? How are mental disorders like and unlike other kinds of ill-health? Does the specialty of psychiatry have a distinctive principle?

iii. According Professor Bluhm, psychiatrists aim to restore "the person" or "the whole person to health."

While I am uncertain what she means by "the person" or "the whole person," I argue for a more limited and distinct aim. I assert that that the psychiatrist aims to restore the *sanity* of the person, that form of health that constitutes organismically, the behavioral and experiential foundations of agency. (See Part Two, "Capacities Implied by "Passing" the Mental Status Exam.") To return to the beginning, physicians are concerned in one way or another to restore or maintain, insofar as possible, the robust organismic foundations of the capacity of persons for human agency. But there is no one physician or single concept of 'health' for all the different occasions for which physicians are summoned.

Response to Dr. Wells

A preliminary note is in order. I do not intend to suggest that "psychiatric disorder is either brain disease or Daly's proposed alternative." Perhaps this reading could have been avoided if a preliminary section of the paper (or a book) had been devoted to a review of the texts indicated in notes 3 and 4 as they bear on the questions I am addressing.

Now to Dr. Wells four criticisms.

i. Medical basis and Psychiatry, Tics, and Psychoanalysis

Medical basis

My paper is concerned with "the principle of discernment in terms of which candidates for classes and for classification [in DSM-5] are identified" (Summary). It is also concerned to offer "a more conceptually elaborate and useful account of the judgment that a person is mentally disordered" than is found in DSM-5. Throughout the paper, the emphasis is on how and what we know when someone asserts *that* a person has a mental disorder. "[T]he argument set forth in this paper is concerned with depicting and understanding *that which is in need of explanation* [mental disorders], with an *explicandum*, not an *explicans*." [i.e., etiology], Note 29. Dr. Wells appears to share this idea when he writes, "Psychiatry deals with insanity irrespective of its etiology."

But nowhere do I argue that ". . . insanity, to be in the province of psychiatry, must not have a 'medical' basis." What I argue is that mental disorders, manifested in experience and behavior, are organismic disorders of human agents and thereby a form of ill-health for which physicians, specializing in the treatment of such disorders, are in fact summoned for the purpose of restoring a kind of health, namely, sanity. That I propose, is the rough and "fuzzy" (see comments by Martin) ba-

sis for understanding psychiatry as a *medical* specialty.

Dr. Wells, however, uses the term "medical basis," in another sense - *to refer to accounts of why or how such disorders come about* by citing references to "brain mechanisms" which in turn, entail reference to the stuff of which human beings are composed, that is, to cells, electrical circuits, genes, the immune system, toxins, etc. Re-reading Parts Two and Three of my paper should make it clear that my depiction of the judgment that someone has a mental disorder does not exclude knowledge any kind from being implicated in the cause and understanding of these disorders - the acts of human agents, acquisitions of all kinds (habits, dispositions, psychological defenses, etc.), biological substrates and their vicissitudes, etc.

Knowing *that* someone has a mental disorder is not radically dependent on knowing *why* a person is disordered in this way. On the contrary. What is entailed in knowing that a person has a mental disorder determines what counts as *knowing* why, namely, when such knowledge contributes to our ability as clinicians to compose an action that effectively and efficiently restores disordered persons to sanity.

Tics

See footnote 9.

Psychoanalysis

Dr. Wells is correct. It is "true of all of us" that we fail on many occasions to author our conduct as we desire or expected to do, while being counted by ourselves and others as sane. Psychoanalysts, physiologists, neurologists, neuroscientists, and the public offer a great variety of accounts of such behavior and moments. But in general, these are not the occasions on which we judge that someone has a mental disorder. (See Daly, 1991) .

ii.a "The paper is ahistoric."

As Dr. Wells correctly notes, I take a contemporary philosophical approach to the questions I consider. My references to the work of others in notes 3, 4, and elsewhere, were chosen to orient the reader to many of the sources that shape my argument.

Certainly there are histories - medical, social, legal, cultural, institutional etc., that bear on such concepts as health, ill-health, sanity, madness, mental disorder, and personality. These matters, which can be relevant to a reading of my text, are simply beyond the scope of the present contribution.

ii.b "Daly equates problems of personality with madness, which is problematic. The psyche, however understood, consists of more than personality."

I do not know how Dr. Wells defines 'personality' or 'psyche.' I do not use the term 'psyche' in this paper. The idea of 'personality' in this paper appears under the title, "Capacities Implied by 'Passing' the Mental Status Exam."

"Personality" is here used in an unconventional way to name what it is about a person as agent that a psychiatrist is evaluating - the operation of an ensemble of capacities manifested in behavior and experience - in order to determine if those capacities are sufficient to enable that person to secure his prudential interests. The further use and meaning of this sense of 'personality' in psychiatry is elaborated in my paper. My definition of the term does not correspond to the diagnostic category, 'personality disorder.' It is offered as a concept consistent with the aims of the paper.

iii. Sanity and the Mental Status Exam

I do not "base 'sanity'" on the mental status exam. I use the features of the mental status exam to *illustrate* the operation of the norms of sanity in clinical psychiatry.

The materials on this exam are introduced to specify a *". . .concept operative in the practices and cultures of the psychiatrist, that is, a foundational mode of good organismic ordering (i.e., of a kind of good health) that is different from the functional integrity of the nervous system . . .* In the initial passages under the subtitle, "What the Examination by the Psychiatrist Requires," I indicate that this exam is but one feature of psychiatrist's effort to reach a judgment regarding the condition of the patient.

Upon analysis, the utility of the mental status exam (when it is of use), is based on our knowledge of sanity. It is our tacit knowledge of sanity contrasted with the diminution or absence of the operation of those agential capacities identified on the mental status exam that enable us, among other procedures, to recognize mental disorders.

iv. ". . . Daly's proposed definition of psychiatry seems to exclude perspective, empathy and solace."

As to excluding (omitting?) "perspective," I am not sure what Dr. Wells has in mind. I think my answers to the two questions I raise count towards a perspective, a way of viewing the origins of psychiatry by examining the common features of 'the first diagnosis.

There are virtues of the good psychiatrist that my paper does not consider, the need for empathy and solace among them. It would be of interest, using the fruits of this paper, to describe the modes that empathy and solace take when the patient has a mental disorder as contrasted with patients who are suffering an illness, or an injury, or degeneration. Such a study would contribute to a definition of psychiatry. Another occasion, perhaps.

Reply to Dr. Bedrick

Dr. Bedrick's comments are generally sympathetic to the broad themes of "Sanity and the Origins of Psychiatry." My reply, therefore, consists of amplifications of features of that paper that address some of his concerns and interests.

i. ". . . "Daly does not follow his insights and arguments far enough . . . because he is at great pains to be sure

that we still see psychiatry as a medical specialty . . . ."

Agreed. That is one of the two related aims of the paper.

"Daly does not follow . . . far enough." Again, yes. Fair enough. Given the point of view developed in the paper, much more could be said about the office and role of the psychiatrist in medicine and more broadly in society. One example. I believe my view helps to illuminate the difference between 'counseling,' primarily concerned with how best to use one's equipment (including personality) as an agent in some situation, and 'treatment,' which is or should be primarily concerned with rectifying the organismic state, condition, or equipment of the agent that impedes the best exercise of one's freedom as an agent. I would, however, resist the idea that these distinctions are always easy, or necessary, to maintain in the practice of psychiatry. My actions as an agent can alter my personality as surely as my personality constitutes an essential feature of my agential capacities and shape my actions as an agent.

At the level of specialization I try to show, *in principal*, that psychiatry differs from other specialties in terms of the nature and range of disorders practitioners attend and to the sort of 'health' we seek to restore or maintain. Because that is the case for the most part, the practical skills or arts of assessment, treatment, rehabilitation etc., differ in many respects from those of other specialties, as do the ensemble of considerations that bear upon good practice. It is not then surprising that the conceptual apparatus and cultures of research, scholarship, and education also differ from those of other specialties - as do the forms of controversy within and about this specialty. More could be said about such matters.

ii Concerning "medical reason" and "medical basis," see my reply to Dr. Wells.

iii. In response to passages concerning agency in Dr. Bedrick's comments that bear on personality, sanity, and mental disorders, I here make explicit several assumptions concerning actions and events, determinism and agency, personality and persons, and the condition or state of the agent who is mentally disordered. This reply is a partial answer to Bedrick's useful question, What is it about madness "that makes us have to stick to the level of the person, or agent?"

Human activities can be understood as (1) movement of stuff e.g., neuro-transmitters; (2) as organismic behavior, e.g., reflexes, habits; and (3) action. Action is the activity of a human being in relation to all that is insofar as it is determined by that person as agent. Action supposes behavior and movement. Behavior supposes movement.

Action involves, in its most developed moments, such matters as motives, knowledge of different kinds including skill, the identification of considerations bearing upon what is to be done, deliberation regarding same, judgment, choice, enactment or performance informed by knowledge and choice relative to some desired good including the avoidance of evils, and the discernment of consequences ascribed to a performance. (Of course, concerning any of these matters, a person can be in error and the agent's intention fail of its purpose.) Activity of this sort does not just happen, is not an event, is something that a person does, something he or she authors in an environment, habitat, community of persons, society. It is activity understood in this way for which persons as particular agents are responsible. As Bedrick says, ". . . freedom cannot be explained in neurological terms, even though our exercise of freedom depends on our brains and not on any immaterial 'mind' or 'soul.'" Right or healthy organismic ordering - the person as organism - enables agency but is not of itself or in itself sufficient to account for or fully understand the activities of a human agent, as agent. To do so, we must recognize the import and utilities of the lexicons and grammars of agency and action *per se*.

As a necessary condition for its possibility, action must be underwritten, sponsored and supported by, a host of events, activities that are not (or not just) authored by the agent but which merely happen, e.g., experiences that are simply given, behavior including habits, and movements of stuff of all sorts that constitute the human organismic foundations of agency and action. How do these events come about? How do these activities underwrite agency? They not authored by us but in some other way - a way to be discerned, if possible, by us, so that we may use such knowledge to improve our lives.

One way of conceiving of organismic ordering is in terms of 'personality' as indicated in my text. The intimate and immediate relationship of the elements of personality to states and to the actions we author or fail to author, is well, though tacitly, known. Sanity, the healthy configuration and integration of personality with the elements of action (knowledge, choice, etc.) is also well though tacitly known and constantly rehearsed. So too with mental disorders, known as I indicated, by the recognition of diminution of the ability to satisfy the norms of sanity that apply to individual persons. The biological determinates of personality are always relevant considerations in clinical work but their immediate salience to judgments *that* someone is sane or mentally ill and in what sense, is often modest.

iv. A person who is initially apprehended as mentally disordered "proves to have a neurological disorder."

There are cases in which the initial presentation of and by the patient suggests a psychiatric diagnosis, e.g., depression, but with time and further investigation, the patient proves to have a neurological disorder, a brain tumor, the 'primary' diagnosis. The initial impression, I would say, is not so much a mistake, as an understandable misapprehension *at the time* of the nature of the case. As noted in the paper, the depression in such a case is subsequently depicted as a manifestation of, or 'secondary' to, the tumor, which is the primary diagnosis. In like manner, an injury, while still an injury, could prove to be self-inflicted, the result of a suicide attempt 'secondary' to a state of depression, which is the 'primary' diagnosis.

v. The promise of the sciences and of resulting technologies.

The judgment *that* a person is sane or suffers as an agent from a diminution of sanity is made on clinical grounds, relative to the norms of sanity and in the manner indicated in my paper. There are speculations, hypotheses, propositions of all sorts - biological (in a narrow sense), social-cultural, psychological, linguistic etc. about *why* people become or may become mentally disordered. These conjectures are warranted because of our current inability to restore many patients to sanity. The 'results' or 'findings' of various sciences and humanities, when reached, are accorded a place in clinical psychiatry by demonstration of their utility in practice.

vi. "That one way or another' and to some extent' are the place markers for some very difficult questions of philosophy and science, and the clearer we can be about those questions the better chance we have of answering them." Yes, indeed.

Reply to Dr. Lewis

I reply to a few passages of the comments provided by Dr. Lewis, those that bear upon his reading of "Sanity and the Origins of Psychiatry."

i. My differentiation of neurology and psychiatry depends on "an ontological distinction" that entails "resorting to a specious Cartesian dualism: an unfortunate fate that befalls Daly in this paper."

I am not and never have been a devotee of the two substance theory. Nowhere in my text do I refer to 'the body' as if there was such an entity or a being as distinguished from the word or concept, 'body'. Nor do I refer to personality, thinking, or feeling as "mental phenomena" as if these terms excluded reference to the activities of a brain.

The distinctions between neurology and psychiatry as medical specialties arise from my experiences as a clinician and from practical considerations, not metaphysical doctrines. I am concerned with the differences between these two specialties as they exist in the present era, not historically, not as they might be at some future time, and certainly not *sub species aeternitatis*. It was not my intent in this paper "to give [or deny] psychiatry a firm foothold in medical science." It was my intent to understand how psychiatry, as a specialty, fits into the current, historically-emergent, institution of medicine.

ii. "Being a good materialist . . . ."

Those committed without qualification to materialistic metaphysics, determinism, and exclusive attention to the neurological basis of consciousness, apprehend all human activities as *events*. For the materialist, human activity is ultimately understood to be the result of the movement of some kind of 'stuff,' or, as organismically determined behavior and experience, 'reducible' in theory, to the movements of material of some sort.

Such commitment without qualification leaves us no way to gain access to the concept of a person *as an agent* that can and does act on the basis of knowledge and choice - and to the practical and theoretical problems associated with this concept. This is a problem. If human agents do not determine anything, do not enjoy freedom of action in any way or on any occasion, they are not in any way responsible for their activities. Everything - self regard, relationships with others, the practice of psychiatry, research, noble or heinous deeds - just happens to happen.

For Dr. Lewis and others, the rule for attending to the events (behavior and experiences) by which mental disorders of persons are discerned is this: reduce those events to "brute facts" in and of and about the brains of human beings. For them, the brain determines human activities in a very strong sense.

The problem is that no compelling reason can be given *for insisting a priori* (before clinical demonstrations of utility) that *this* is the only rule that could be followed in attending to the events by which mental disorders are discerned. And in my paper, as Dr. Lewis observes, I do not follow such a rule. In the search for why people have mental disorders, one could stipulate a different rule: attend to the events in question as manifestations of faulty learning about relations with others. But there is no good reason, save for demonstrations in practice, *to insist that this must* be the rule either.

Using a lens that refracts only blue light to examine an object, I will see only the blue light emitted by the object, if it emits any. The fact that I use *this* lens to examine an object does not determine that *the object* I am examining exhibits blue light.

iii. "Daly's argument hinges on the assumption that . . . the person-level features of madness suggest the irreducibility of . . . mental phenomena relevant to psychiatrists to brute facts about the brain."

I assume throughout my text that the brain is an organ, part of the whole of the material of which we are composed. I also assume that its functioning is known to underwrite the possibility of all our activities. On my view, sound functioning of a brain is not 'the' but 'a' necessary, though not sufficient, condition for the presence of experience, behavior, and action.

iv. Dr. Lewis writes, while "higher-order mental phenomena (personality, beliefs, feelings) are unlikely to be entirely reducible and fully characterized" by the neuro-sciences, "this does not imply that these phenomena are not *brain* phenomena. What else could they possibly be?" While the classification of ill-health as mental disorders is heavily shaped by social, cultural, and political factors, these factors are ". . . mediated by the brain" and play a role "only insofar as they affect the brain. What am I missing here?"

In reply, I provide a schematic note on "higher order," and "person-level." (See my reply to Dr. Bedrick.) Though my paper is not about *why* people are mentally disordered, I offer this brief and simple sketch of background assumptions that, in my view, set the stage for answers to those questions.

In the vocabulary and grammar of "Sanity and . . . ", the person exists as an agent, capable of authoring or originating actions. But to exist as an agent, it also necessary that the agent be a non-agent, a human organism living in

an environment. That which pertains to the person as organism - i.e., the organismic features of a person - are known by reference to biological functions and mal-functions of that individual. These include the habitual aspects of a person's relationships with others. 'Personality,' the organismic foundations of behavior and experience, is one way to construe the existing human individual as an organism, not as an agent. To be a human organism presumes that the organism is composed of materials essential for generating different organismic functions and malfunctions. Hence, the events by which mental disorders are identified can arise from many quarters, from whatever underwrites 'personality,' and in that way, assures our capacity, as persons, for action.

v. "I am not reassured by Daly's confidence in the mental status exam as an epistemological tool . . . in establishing what he describes as 'sanity' . . .. I do not employ the mental status exam to *establish* sanity. I use this common clinical device to *illustrate* the operation of and conceptual necessity of a medial concept of sanity. (See also Reply iii to Dr. Wells.)

Reply to Dr. Chardavoyne

I address Dr. Chardavoyne's comments under two headings:

i. comments that bear directly on my paper; and,

ii. a comment which proposes a somewhat different answers to the questions I seek to answer.

i.a His reading of my definition of health and ill-health - "the capacity for relations with others and dysfunctions in that capacity" - omits essential features of those definitions.

Health, as I define it, is the *organismic capacity* of a person considered as *an agent*, to secure his *prudential interests* in the course of *living his or her life*, and is among the *goods* considered requisite for human flourishing. It is in the light and within the context of these considerations that I include, importantly, the organismic capacity for relationships. It is the diminution of this capacity, not just in relations with others, but with regard to all the furniture of the universe, persistently, and with regard to securing prudential interests, that a human being's ill-health is most clearly recognized.

i.b "Daly describes how psychiatrists consider the capacity for interpersonal functioning, although does not elaborate on this important aspect of psychiatric practice."

My paper is not about explaining or understanding why patients become disordered. Nor is it about psychiatric practices. I ask and try to answer two related and important questions: What and how do we know when we judge that someone has a mental disorder? How does the answer to this question enable us to legitimate psychiatry as a medical specialty?

ii. Dr. Chardavoyne asserts that "the concept of the self in relation to others . . is a primary focus of psychiatry" and "a main reason why psychiatry differs from neurology."

The concept of the self as agent acting in relation to others is foundational (1) when judging *that* someone is mentally disordered as well as for many other judgments, (2) for formulating *why* some people suffer some kinds of mental disorders, and (3) when treating persons with some kinds of these disorders. As Dr. Chardavoyne says, It is given greater emphasis in the clinical cultures and practices of psychiatry than in the cultures and practices of neurology that are animated by a concern with the healthy functioning of the nervous system. But while I agree that interpersonal relations are often "a primary focus of [clinical] psychiatry," I would not and do not argue that this fact is "a main reason why psychiatry differs from neurology."

In my view, the importance of the self as agent in relations with others (Macmurray 1957,1961) arises from what we have learned in the clinic about how and why many people are mentally disordered. And to date, more, though by no means, all of the determinates of personality useful in clinical psychiatry, are patterns of determinates more or less associated with what is experienced and learned in the course of living a life.

But a strong justification for identifying psychiatry as a medical specialty cannot be made on this basis. A strong case, which I attempt to make in my paper, is here presented in a schematic form:

Sanity is a form of the health of persons.

Mental disorders are diminutions of this form of health, a kind of ill health.

Medicine is a historically-emergent social institution to which persons with ill health turn to seek aid.

Physicians are members of this institution who provide aid.

Some physicians, called 'psychiatrists,' attend to persons who seek aid for mental disorders.

Notice that my view of a strong case does not depend on any mode of explaining or justifying *why* persons are mentally disordered. It depends in practice and in principle on an account of what sanity amounts to. Reaching that account employs, at the beginning, an analysis of the common features of the judgment *that* someone is mentally disordered, someone who is not simply sane. That is the judgment that precipitates all that follows, including psychiatry.

Explanations and understandings of why people become mentally disordered which serve as rationales for various treatments, are, of course, vital to the work of the clinical psychiatrist. But such explanations etc. are many, changing, and problematic whether they concern interpersonal relations, neural pathways, genetics, or the stars. The do not furnish good reasons for justifying a claim with staying power that psychiatry is rightly regarded as a specialty of medicine.

Reply To Dr. Martin

Dr. Martin provides readers with an energetic, informing, and rich commentary which, in general, places the themes of my text in broader contexts

than I do. I reply, therefore, to selected passages in Dr. Martin's response related to his reading of my paper.

These passages concern i. the philosophy of medicine, ii. the meaning of 'open textured,' iii. psychiatry as science, iv. what 'the first diagnosis' means, and v. psychiatric disorders as social disorders.

i. Dr. Martin finds the philosophy of medicine to be a problematic beginning point for my reflections. As I am seeking to understand psychiatry as a specialty of medicine, I thought it imperative, at the outset, to make explicit my assumptions concerning 'medicine' as a social institution.

There was but a modest amount of work done in the philosophy of medicine by philosophers prior to WW II in America. From the later part of the twentieth century to the present day, however, there has been considerable philosophical literature generated in the United States and elsewhere by philosophers, physicians, and others. Consider, for example, the work found in The Journal of Medicine and Philosophy, Philosophy, Psychiatry, & Psychology, and the series of books, Philosophy and Medicine (Springer). These and other contemporary sources cited in the paper (e.g., Canguilhem, Fulford, Kass, Margolis, and Radden) do fund my text. If that funding is insufficient, it would helpful, via philosophical argument, to know why.

ii. I write, "Aside from the general features . . . set forth, 'sanity (like 'madness') is a term that is 'opened textured' or subject in use to variable specifications, senses, valuations, and interpretations." (p.20) .

Dr. Martin writes, ". . . I would emphatically disagree with Dr. Daly on this count."

I am not certain about the nature of this disagreement. I *think* my assertion about judgments being "opened textured" is the "count" with which he disagrees. I may be wrong. In any event, from his text, I gather that my remarks about "open textured" imply, for him, the following: a proposition: "What comprises madness here and now, might not then be madness a hundred years from now;" and, ignorance (maybe) on my part: ". . . there has always been clear recognition of madness with consistent symptomatology, dating from the earliest written records."

Clearly, the setting for my text is clinical psychiatry of the present era. I have no foreknowledge of DSM-30, if there is one. Nor am I altogether ignorant of the history of psychoses in the West of which Dr. Martin writes with considerable authority.

So what is the problem here? I suggest that "open textured" is too opened textured if it can yield these implications.

"Open texture is a term in the philosophy of Friedrich Waismann, first introduced in his paper *Verifiability* [1945, p.2] to refer to the universal possibility of vagueness in empirical statements.[1] The concept has become important in criticism of verificationism and has also found use in legal philosophy."
http://en.wikipedia.org/wiki/Open_texture

a. The footnote in the "Summary," found at the beginning of my paper, indicates why I use the terms 'sanity' and 'madness.' There are no satisfactory terms in English for the range of conditions with which psychiatrists are concerned. Using these terms does run the risk that they will be conflated with other usages found historically in medicine, legal institutions, literature, and philosophy in the West.

b. The "variability" in the states of persons reasonably considered to have 'mental disorders', occurs under the penumbra of the features of the first diagnosis and related materials about sanity, thus constraining the usage of these terms. As to "madness is madness," contemporary society and psychiatrists in particular, include both non-psychotic as well as psychotic states of persons in the inventory of mental disorders. Both need to be accommodated, within limits, by a medical concept of sanity and of mental disorder. 'Madness,' as I use it, also includes states that have been recognized, as Dr. Martin indicates, for millennia. Why the same kind of mental disorders are recognized in different times and cultures and others only in specific settings is an important matter which is beyond the scope and intention of my paper.

c. Indicating that there is variability in the way first diagnoses are made in the present era does not imply that a state of affairs can credibly be a mental disorder just because someone with social authority or power says so. Neither do I insist that the idea of 'sanity' and of 'psychiatry' has or will have the precision and enduring qualities of say, the definition of sodium in the table of elements. There are "fuzzy boundaries" when discerning and naming the states of persons, but boundaries nonetheless.

d. Dr. Martin indicates that "subjective" is a cognate of 'opened textured' "again pointing to psychiatry as a social science."

'Subjective' has a nest of meanings, but not as a cognate of 'open textured.' The meanings of 'subjective' include (1) a reference to the self as subject in a political sense, (2) to characterize a person's experience, perception, thinking, or emotional state usually without reference to reason, or reasons, and, more generally, (3) as that in which 'mental' attributes inhere, i.e., the subject of consciousness. It is often used in contrast to 'objective' - impersonal knowledge about that which is thought about, perceived as, or otherwise experienced in this or that way. This contrast is often drawn in a pejorative or critical tone to highlight the absence of 'objective' knowledge in a judgment, of even the absence of judgment. By contrast, 'open textured' implies that a statement reasonably and commonly admits of different applications or interpretations in different situations without being vacuous or devoid of steady meaning at some level of abstraction.

iii. Dr. Martin speaks on several occasions about "the science of psychiatry," of psychiatry as "a social science," and claims that my paper implies that

"psychiatric disorders are indeed social disorders."

Clinical psychiatry is a craft comprised of various skills directed at securing a practical end, the restoration and/or maintenance of the sanity of individual persons as agents. While the practices of this craft have developed and regressed on the basis of trial and error, such practices are informed, as (Dr. Martin notes with approval) by the "findings of a wide and diverse set of sciences and humanities," insofar as they prove in fact to be useful to fostering the realization of the practical end of psychiatry.

Psychiatry is regarded as a learned *profession* insofar as its practitioners are acknowledged to *know* as much or more than any other occupation about how and why their craft is practiced in the way it is. This knowledge may be what Dr. Martin means by "the science of psychiatry."

Psychiatry, as a kind of knowing, is not a science that has as its aim, simply knowing or discovering that something is the case about a class of phenomena. Nor, in the same spirit, do I hold that psychiatry is "a social science" akin to disciplines such as history, anthropology, and sociology. Clinical psychiatry is not a speculative science. The clinician composes knowledge of many different types to achieve a practical aim.

iv. ". . . madness is not diagnosed based on scales of sanity, but rather on the ability to function relative to societal expectations. The implication is that madness is more of a social disease especially if it is true that the initial diagnosis is a 'lay' diagnosis."

The norms of sanity are not formally scaled but largely tacit. Sanity is one of the conditions *constituting* the ability of a person as agent to function relative to societal expectations, but only one of the organismic foundations of that ability.

All radical forms of ill health are initially known via lay judgments relative to expectations for organismic capacities *of different sorts* required of persons to secure their prudential interests. So in that regard, judgments about mental disorders are no more 'social' than judgments regarding any other form of ill health - other "first diagnoses" are also social and cultural - other lay judgments that someone is 'ill,' 'injured,' 'malnourished,' 'in pain,' or 'deformed' - that is, organismically impaired.

It is the appreciation of ill health by the laity, as Canguilhem observes, that leads the patient or his surrogate to call the physician and establish a relationship intended by both parties to restore the patient to 'health' of some kind. Physicians, in general, do not make first diagnoses except incidentally, on routine examinations at the request of the patient, or, at the behest of third parties, when examining persons who believe (incorrectly) themselves to be in good health.

If this line of thought is correct, then mental disorders are not, as Dr. Martin asserts, "more of a social disease especially if it is true that the initial diagnosis is a 'lay' diagnosis."

v. Near the end of his comments, Dr. Martin, ((perhaps in agreement with Luchins (2010)) reminds the reader that despite enormous expenditures in recent years for various sorts of biological research, "Not one meaningful new treatment has emerged." This history, he claims, lends "support to Dr. Daly's theses that psychiatric disorders are indeed social disorders."

The intent of my paper is to show why mental disorders are and can be regarded as *medical* disorders, organismic disorders of human agents to which psychiatrists attend. In keeping with this proposition, I offer a rationale for why psychiatry is and should be designated as a medical specialty. In sections ii-iv above, I address Dr. Martin's contentions that my work implies that psychiatric disorders are social disorders.

That said, I am not sure what he means by "social disease" or "social disorder" because he does not tell us.

Perhaps he means that much of what we do know to date that proves useful in practice about *why* people suffer mental disorders (not straight forwardly the result of insults to their brains) derives from what has been learned in the clinic (including the clinic of "psycho-pharmacology") rather than in the dissecting room or the laboratory. Such knowledge is not folk knowledge. It is gained and persistently refined in practice, over time. To a considerable extent, that is knowledge of how, *given* our human endowments, as individuals, each of us acquires, in and through our relations with others, the ordered behavioral and experiential foundations of an organismic capacity to author, to some extent, our own activities. Again, perhaps that is what Dr. Martin has in mind by his use of the phrase, "social disorder." Consult also my reply to Dr. Chardavoyne.

Given that current clinical knowledge is not sufficient to generate treatments that are efficacious in many cases, there is no good reason to cease our interest in how the elements of personality are acquired, or, to forsake inquiry into the ways in which endowments engender or fail to sustain sanity. Nor is there a good reason to insist that one sort of inquiry *must be* the answer to our quest to achieve the practical aim of psychiatry.

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(Continued from page 1, Editor)

with all due respect for the many exceptions, that psychiatry treats disorders of the mind, while neurology treats diseases of the brain? A delusion is different in kind from a broken leg. This is an ideal-type polarity whose purpose is to highlight the emphasis of each specialty.. Of course psychiatry treats the brain (Alzheimer's) and neurology treats the mind (delusions of tumors), but the ideal-type distinction remains useful.

I now hear the chant of objections from all sides. Let me mention three.. Some would argue that the overlap is too great for a straightforward mind/ brain divide of the two specialties. Others would argue that, anyway, mind is nothing but a function of brain. Finally, our author, Robert Daly, might argue that all the above territory is covered by his concept of the 'organismic'. To the first I would question how we are to distinguish the specialties if not by such a distinction (yes, I vote for distin-

guishing them)? To the second I would ask just what 'function of the brain' (or 'mediated by the brain', or Andreasen's 'expression of the brain') is supposed to mean. Don't they all mean whatever we want them to mean. Finally, to Daly's suggested challenge, I would answer, of course; it's all a matter of whether the concept 'organismic' can carry the weight assigned to it.

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(Continued from page 1, President)
looking at the world. I couldn't be happier with my path. I can't wait to see where my niece's takes her.

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