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Externalist Psychiatry

ABSTRACT: Psychiatry widely assumes an internalist biomedical model of mental illness. I argue that many of psychiatry's diagnostic categories involve an implicit commitment to constitutive externalism about mental illness. Some of these categories are socially externalist in nature.

KEY WORDS: Psychiatry; Externalism; Mental Illness

What is the nature of mental illness? Ask a psychiatrist, and a likely answer will be that mental illnesses are neural dysfunctions, disorders of the brain. This reflects the dominant *biomedical model*, described by Zachar (2000: 21):

Biomedical materialists claim that psychiatric disorders are best conceptualised as brain diseases. Many of them think that psychological analyses are irrelevant for understanding the nature of psychiatric disorders. Thinking that psychiatry should approach its professional problems as scientifically as possible, they usually downplay the distinction between psychiatry and neurology. Some would prefer that these two specialties be merged.

The biomedical model is metaphysically and epistemically reductionist. On this view, the nature of mental illness is exhausted by neurological properties and events, and all facts about such conditions are scrutable from neural facts. The biomedical model also implies internalism about psychiatric disorders: features of the subject's neurophysiology suffice to determine whether or not she has a particular mental illness.

Given the externalist (not to mention non-reductive) trends in philosophy of mind over the last forty years, psychiatry's adherence to this model may seem surprising. And yet few attempts have been made to assess or develop externalist views in psychiatry. Existing attempts have also been fairly programmatic, simply assuming an embodied view of cognition (Drayson 2009) or vehicle

externalism (Sprevak 2011). I examine psychiatry's conceptual commitments more directly. I argue that many of psychiatry's diagnostic categories are implicitly committed to constitutive externalism about mental illness. Some of these categories are socially externalist in nature.

Argument

I aim to establish instances of the following externalist schema. For individuals *S* and psychiatric categories *C*: necessarily, if *S* instantiates *C*, then *S* stands in relations to certain kinds, events, individuals, practices, or institutions, in her wider natural or social environment. The schema 'says' that some relations borne by *S* to her environment place constitutive conditions on her having mental illness *C*. By a 'constitutive condition', I mean any condition that specifies – in part or whole – the nature of a given kind or entity.

We can distinguish between historical and contemporaneous constitutive conditions, that is, between conditions that must have obtained at some point in the causal history of *C*, versus conditions that must obtain at some time during which *C* is exemplified. As an example of the latter, perhaps being disposed to assent to *p* is a contemporaneous constitutive condition on believing that *p*. Necessarily, if *S* believes that *p*, then *S* is disposed to assent to *p*. As an example of the former, being caused by the indentation of a foot presumably is a historical constitutive condition on being a footprint. Necessarily, if *x* is a footprint, then *x* was caused by the indentation of a foot.¹ A more pertinent example: externalists about content take the causal relations between an individual's mental states and the kinds or practices in her environment to place historical constitutive conditions on the types of mental representation of which she is capable. What determines that my WATER thoughts represent *water*, as opposed to *twater*, is in part that my environment has put me (and other members of my linguistic community) in causal contact with the kind *water*, and not *twater*. Or so the thought goes.²

One route to an externalist psychiatry, then, would be to argue that some mental illnesses possess wide historical constitutive conditions. Take posttraumatic stress disorder (PTSD). PTSD

¹ Stalnaker (1989).

² Another path to externalist psychiatry would be to assume content externalism, and argue that mental illnesses are constitutively representational. As noted above, my approach is more direct.

involves a range of positive and negative symptoms, including the involuntary intrusion of distressing memories, extreme irritability, and hypervigilance. As the name suggests, however, PTSD as a diagnostic category is reserved for subjects whose symptoms follow exposure to trauma. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) criteria for PTSD require that the patient has been exposed to ‘actual or threatened death, serious injury, or sexual violence’ (DSM: 271). Similar restrictions apply to reactive attachment disorder (RAD) in children. RAD presents with consistently withdrawn and unresponsive behaviour towards caregivers. As the term ‘reactive’ suggests, RAD marks a response to highly unfortunate social circumstances. Specifically, it is a ‘diagnostic requirement’ for RAD that ‘the child has experienced a pattern of extremes of insufficient care’, through neglect, deprivation, or repeated changes in the primary caregiver (DSM: 265-267). In both PTSD and RAD, then, prima facie it seems that the category entails a relevant environmental trigger for the patient’s symptoms.

While alluring, these examples will not convince everyone of psychiatry’s externalist commitments. It may be objected that the argument confuses epistemic criteria for mental illness with constitutive conditions. Evidence of past trauma facilitates clinicians’ identification of PTSD, the objection runs, just as evidence of mosquito bites increases our credence that feverish symptoms are due to malaria. But this does not establish a constitutive connection. The DSM is a diagnostic tool, after all, not an exercise in conceptual analysis.

A more compelling example involves depression. According to the DSM, the core features of ‘major depression’ are a prolonged period (2 weeks or more) of depressed mood or anhedonia (DSM: 160ff). Other symptoms include, inter alia, fatigue, impaired concentration, and insomnia. As Horwitz and Wakefield (2007: 53ff) have argued, however, the DSM’s emphasis on individualistic, phenomenological, criteria invites a ‘decontextualised’ view of depression that is at odds with a ‘contextualised’ concept pervading 2,500 years of medical history. On the latter view, depression crucially involves states that are *unwarranted* by or *disproportionate* to events in the subject’s life. Aristotle thus characterised ‘melancholia’ as a sadness that is ‘cold beyond due measure’, producing a ‘groundless despondency’. Similar remarks appear everywhere from tenth century Arabic physician

Ishaq ibn Imran, through to nineteenth century psychiatrist Henry Maudsley. These thinkers recognised that when feelings of emptiness or hopelessness are divorced from their causal context, even those experienced for prolonged periods or to an extreme degree are insufficient to distinguish pathological depression from normal sadness. Given a suitably dystopian context, devoid of any reason to be happy, even the severest depressed mood might not qualify as pathological. The facts that determine whether or not an individual is depressed therefore must include facts about her environment. In particular, necessarily, if *S* has depression, then the states and events comprising *S*'s depressive symptoms are not an appropriate or proportionate response to antecedent events in her environment.

Two clarifications. First, this view does not entail that pathological depression is always 'without cause' or 'endogenous'.³ Depression can be (and often is) precipitated by events that would reasonably be classed as saddening or tragic. The point is that the subject's response may become pathological if its severity or duration exceeds some contextually determined threshold for appropriateness or proportionality to these events. Second, the view is consistent with the thought that depression involves some neurological or psychological dysfunction. The claim simply is that such dysfunctions do not fully capture the pathological nature of depression. This reflects the dominant, historically grounded, concept, if not the current clinical zeitgeist.

A second route to externalist psychiatry focuses on contemporaneous constitutive conditions on mental illness. Some disorders class as externalist by virtue of their necessary social manifestations, as opposed to their environmental antecedents. Consider oppositional defiant disorder (ODD). ODD is an 'externalising' disorder, which manifests in pathological or harmful behaviour towards others. Specifically, ODD involves behaviour that is repeatedly and persistently uncooperative or argumentative, violating age-appropriate societal norms. Attributions of ODD imply the existence of multiple acts of defiance towards an authority figure or social rule. If the patient were not to have instantiated such social relations, then the classification of ODD would not apply. Similar

³ Kiloh & Garside (1963).

points apply to other disorders of impulse-control, such as conduct disorder, pyromania and kleptomania, as well as antisocial personality disorder.⁴

An internalist might object that ODD surely consists in the subject's dispositions to behave defiantly, and that such dispositions are narrowly constituted. In response, one option would be to deny the second conjunct, and argue that these behavioural dispositions are extrinsic (McKittrick 2003). My strategy, in contrast, is to reject the claim that ODD is solely constituted by a set of behavioural dispositions. This is mistaken: simply put, there is no conduct disorder without at least some disordered conduct.⁵ The mere disposition to behave defiantly is not sufficient for ODD, any more than a disposition towards a depressive mood is sufficient for depression. As understood clinically, ODD requires the prolonged manifestation of defiant behaviour, just as depression requires the prolonged manifestation of a depressive mood. Manifesting a disposition to defy authority or societal norms, moreover, entails the presence of some such authority or norm, just as manifesting the disposition to dissolve in water entails the presence of water. A diagnosis of ODD is therefore existentially committing with regards to features of the patient's social environment.

We can argue the point another way. Take an individual with exactly the same narrow dispositions as someone with actual ODD, but who is located in a utopian, egalitarian, world in which all asymmetric power-structures have been abolished. Would it seem right to classify them as having ODD, even though their social environment presents no opportunities to defy authority? I suggest not.⁶

Similar points apply to conditions such as avoidant personality disorder and selective mutism (SM), an anxiety disorder in children. Regarding the latter, SM is characterised by the failure to initiate speech in certain social contexts, or to respond when spoken to by others. The mere disposition to remain mute, while clearly a sustaining feature of the condition, is insufficient for

⁴ Lest there be concerns that the argument focuses on fringe categories within psychiatry, note that impulse-control disorders are the second most prevalent type of mental illness, with a lifetime prevalence of around 25% in the population (Kessler, R. C. et al. 2005). The prevalence of ODD is around 10%. And depression, of course, poses one of greatest public health problems in the world today.

⁵ Compare Graham (2010: 132).

⁶ Levy (2013) runs a similar argument in the case of addiction.

disorder. Consider an individual with all the narrowly constituted dispositions of SM, but situated in an environment in which risk of fatal infection has forced the cessation of all face-to-face communication outside the home. Does it seem plausible to attribute SM in this case, even though the envisaged scenario presents no opportunity to manifest socially inappropriate unresponsiveness? Again, I suggest not.

As a final example, consider factitious disorder (FD) imposed on the self or another. FD involves sustained attempts to mislead or deceive others regarding one's own health or that of another. Via the standard 'addressee condition' on deceiving, FD entails the presence of someone within the subject's environment to whom the deceit is addressed.⁷ One objection is that FD might involve attempts to deceive oneself, thus presenting a putative case without external commitments. The presence of self-deception, however, more plausibly would indicate an illness anxiety disorder or extreme hypochondria, rather than FD. The clinical concept of FD is assuredly externalist in nature.

The examples discussed span a wide range of psychiatric categories. Depression and impulse-control disorders, moreover, are among the most socially significant illnesses in all of psychiatry. It nonetheless may be objected that these cases only force a minor qualification on biomedical materialism. After all, nobody denies that the brain is the crucial mechanism in mediating environmental influences and sustaining the behavioural manifestations of mental disorders. But this is beside the point. The same could be said regarding the brain's role in sustaining perception and thought, yet nobody would dismiss the twin earth arguments as a mere footnote to content internalism. Content externalism admittedly has not changed the practices of vision science, and the juggernaut of neurobiological psychiatry will not deviate in response to the preceding arguments. As a general thesis about the nature of mental disorder, however, biomedical materialism must fall.

Conclusion

As a branch of medicine, psychiatry has long faced pressure to adopt a biological, disease-based, model of mental illness. To some extent this is fair enough: the biomedical approach has remarkably

⁷ Simpson (1992).

improved our understanding of somatic illnesses. But mental disorders are profoundly different from somatic illnesses in at least one respect: many mental illnesses satisfy the externalist schema, whereas somatic illnesses do not. Unlike lung cancer or coronary heart disease, depression constitutively depends on complex relations between subject and environment, ODD requires manifest social defiance, and SM implies marked conversational unresponsiveness. By excluding environmental factors, the biomedical model presents an impoverished view of the nature of mental illness. Psychiatry henceforth must take a broader view.

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