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**Making Order out of Disorder:  
on the Social Construction of Madness**

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Contemporary enthusiasm for social constructivist accounts -- of most everything -- is both exciting and exasperating. On the one hand, very concretely, it has greatly increased our understanding of the ways that social values and priorities have affected the history of medicine, music, marriage, and much else; and it has been remarkably effective in undermining pernicious notions of gender, race, and intelligence, for example. On the other hand, more abstractly, it has encouraged the view that social values and priorities are the sole historical determinants of medicine, music, and marriage; and it has helped create a culture in which the distinction between what is real and what is contrived, or between how things are and how things are thought to be, threatens to disappear entirely. This tension between the promise and the dangers of social constructivism is especially sharp in the case of mental disorders or madness, where disclosing the social agendas that often guide diagnoses can lead to more self-searching, case-specific interventions while also fueling the conviction that there is nothing 'really' wrong with those who are mentally ill -- that madness is nothing more (and nothing less) than what we make of it.

Social construction in general is not particularly popular among psychiatrists, but it is certainly the dominant theoretical framework within the broad field of work now known as "cultural studies".<sup>i</sup> And social constructivism about madness, in particular, has attracted a steady following ever since the early work of Michel Foucault and Thomas Szasz became popular in the 1960s.<sup>ii</sup> I shall not attempt a history of this movement but I will attempt to answer the following three questions:

1. What does it mean for a mental disorder to be socially constructed?
2. How can we decide whether or not a mental disorder is socially constructed?

3. What are the practical implications of deciding that a mental disorder is socially constructed?

These might be called the metaphysical, epistemological, and ethical questions, respectively; as we shall see, though, the traditional separation and ordering of these categories is part of what social constructivists seek to challenge.

## I

The notion of *social* construction emphasizes the importance of societal conditions as opposed to individual beliefs and desires, on the one hand, and as opposed to physical forces, on the other.<sup>iii</sup> Societies are composed of individuals and individuals are composed of physical parts, of course, but these facts do not require that a society's condition be *explained* in terms of individual beliefs and desires or that an individual's beliefs and desires be *explained* in terms of physical forces. Depressive disorders, for example, may involve individual beliefs and desires and may involve physiological changes without being explained by these things if the underlying causes are primarily social: the breakdown of family ties, the loss of meaningful work, the decline of religion, and so on.<sup>iv</sup> Similarly, certain neuroses, manifest in an individual's beliefs and desires, might be viewed as psychic irruptions of social practices which have been repressed.<sup>v</sup>

Of course, the idea that various instances of madness can be *caused* by one's social surroundings is not new, and is not particularly controversial. Betrayal by one's friends and family can cause psychotic rage, the loss of one's home can cause profound depression, and belonging to an obsessive profession can cause one to develop an obsessive personality. Fiction as well as life is full of instances of madness brought on by such circumstances: Clytemestra's murderous rage in the face of Agamemnon's betrayal, Werther's depression upon losing the woman he loved, Judith's obsessiveness in response to that of Bluebeard. And the psychological literature that identifies social factors contributing to mental illness is enormous. But the notion of *construction* is somewhat different than that of cause. Construction implies the emergence of some new *structure*, in which various items or various features, previously separate, are brought together to form a new whole. In a very literal case of construction, such as the construction of an anthill by a colony of ants, bits of dirt and food and bodily secretions

that were previously separate are combined and rearranged to form a structure that sustains the life of that colony. In the case of a socially constructed mental disorder, an assortment of behaviors and experiences will be brought together and ordered in some new way that plays a role in the life of that society. In just what sense, though, can social conditions bring different experiences and behaviors together into a new whole? We cannot simply pick them up and carry them, antlike, to their newly assigned locations next to one another.

There are two basic possibilities: first, social conditions may create lawlike regularities between experiences and behaviors that were previously disparate or non-existent (whether or not we recognize or conceptualize these new regularities); and second, social conditions may create the *belief* that there are lawlike regularities between experiences and behaviors where there are in fact none (with the further possibility that these beliefs will actually produce the regularities in question). Anorexia appears to be an instance of the first sort -- where a refusal to eat, perfectionist tendencies, delayed psychosexual development, and a distorted body image began to co-occur regularly in America, in the later part of the twentieth century, in response to some very specific social forces (and where the concept of anorexia followed the reality of this convergence of symptoms). Borderline personality disorder appears to be an instance of the second sort -- where the idea of an identity disturbance, of manipulative social relations, of affective instability, and of self-destructive behavior are brought together under a single concept without there being (or prior to there being) any lawlike relations between these experiences.<sup>vi</sup> This second possibility, in which psychological regularities are posited where there are in fact none, is of particular interest to those who believe that the whole point of a mental disorder is its refusal to adhere to lawlike regularities, as well as to those who believe that there is no order in the world apart from the order that we project onto it.<sup>vii</sup> Whether or not there is such a thing as a natural order, though, a social disorder that is socially constructed is not something that already exists as a unity within that natural order.<sup>viii</sup>

Bringing disparate features together under a new concept, and believing that these features belong together (the second possibility) may, of course, produce lawlike connections between those features (the first possibility). We are highly

suggestible beings, especially in therapeutic contexts, and others' expectations about what behaviors and experiences belong together are often made true by our responsiveness to those expectations. Predicting auditory hallucinations in someone who has been called schizophrenic, or supposing that childhood abuse will result in a multiple personality disorder, may in fact bring about the expected outcome (by offering a novel interpretation of what might otherwise be experienced as merely talking to oneself, or by suggesting an effective way of escaping from one's pain).<sup>ix</sup> This will be particularly true of so-called personality disorders -- paranoid, schizoid, antisocial, borderline, narcissistic, dependent, obsessive compulsive, or passive aggressive personalities -- insofar as our self-definitions are particularly responsive to social expectations.<sup>x</sup> (Judgments about the sort of person one is operate at a more theoretical level than judgments about what one feels, what one remembers, or how one will behave in a particular situation; and for this reason, we are more dependent on the judgments of others when it comes to deciding personality types.)

Succumbing to the power of suggestion may or may not involve the activation of a common cause for the relevant behaviors and experiences. Deciding that we are depressed may actually alter our serotonin uptake profile (an instance of what Hacking calls "biolooping"<sup>xi</sup>), or it may simply encourage us to behave in the ways we are expected to behave, and to interpret our experiences -- sensations of numbness, sleeplessness, lack of concentration, etc. -- as signs of depression, with the result that the occurrence of one symptom makes an occurrence of the others more likely (what Hacking calls "classificatory looping"<sup>xii</sup>). It would be wrong, however, to assume that alterations of the first sort create 'real' instances of depression while alterations of the second sort create only 'imaginary' depression. In either case, there is a lawlike regularity between certain defining symptoms; and while the presence of an underlying disease may affect the treatment of a mental disorder, it doesn't affect its reality.

In addition to there being two basic *ways* in which social construction can occur, there are several *levels* at which a societal construction can occur. At the most general level, a society might be said to construct mental states as *disorders* insofar as it creates the rules of rationality or mental 'order' against which aberrant experiences and behaviors get grouped together (in thought or in reality) into *disorders*.<sup>xiii</sup> This is the

level at which it is easiest for social constructivists to make their case; for there is no question that different societies have drawn the line between normalcy and madness in different ways, and that disparate experiences and behaviors that are deemed mad come to be correlated with one another -- both in thought and in reality.<sup>xiv</sup> (For this reason, if no other, the DSM's insistence that "conflicts that are primarily between the individual and society" are not mental disorders will be unconvincing to many.<sup>xv</sup>)

At a somewhat less general level, the social constructionist may claim that a society is responsible for creating the particular *groupings* of syndroms that constitute disorders such as hysteria, depression, paranoia, attention deficit disorder, anorexia, borderline personality disorder, schizophrenia, and so on. In our society, various experiences of inner voices may be grouped together and may reinforce each other to create the syndrome of schizophrenia while, in another society, they may be treated as unrelated instances of daydreaming, remembering conversations, listening to the gods, or communing with one's ancestors -- with the result that various experiences of inner voices do not tend to reinforce each other and support lawlike generalizations. Likewise, a range of behaviors that count as unrelated cases of investigating, organizing, or planning in our society may add up to obsessive-compulsive behavior in another society. To establish the social constructivist thesis at this level, it is not enough to show that some societies do not have the concept of "paranoia", for example (since the reality may exist without the concept), or do not treat those who imagine they are being persecuted as mad (since the relevant syndrome may exist without being considered abnormal or insane); one must show, rather, that the experiences and behavior that we define as paranoid do not regularly co-occur in these other cultures (and perhaps not even in our own).

Finally, at a still more detailed level, a society may construct the very behaviors and experiences in terms of which mental disorders are defined: flat affect, delusions, confusion about identity, antisocial behavior, disordered thought, and so on. Experiences that we group together as instances of flat affect may be variously thought of as instances of mature, considered, restrained, or subtle feeling within another society.<sup>xvi</sup> Or what we group together as delusions may be viewed as unrelated instances of fantasy, visions of an afterlife, and normal misperceptions within another

society.<sup>xvii</sup> To be a social constructivist at this level is to be a social constructivist about the very experiences and behaviors that make up a disorder. And, again, this later possibility is of particular interest to those who believe that there is no preexisting structure in the world -- no such thing as a 'natural' order of things. ("It's turtles all the way down.")

Because I find social constructivism concerning the broad category of madness (or mental disorder, or mental illness) uncontroversial, and I find social constructivism about such experiential categories as flat affect and delusions implausible (I say a bit more about this below), the discussion in this paper is mainly focussed on social constructivism about diagnostic categories such as schizophrenia, depression, borderline personality disorder, and so on.

Before we consider the sorts of evidence that are relevant to establishing social constructivism at this level, it is worth noting the range of social conditions that might contribute to the construction of a mental disorder. In the case of anorexia, relevant social factors seem to include advertising's promotion of thinness, an explosion in the achievements (and hence the expectations) of women, and economic conditions that cast a pall over the future. In the case of borderline personality disorder, relevant social factors seem to include the fact that insurance companies demand labels for the disorders whose treatment they are willing to cover, and the fact that the introduction of medical jargon is one way to counteract a patient's manipulateness. The resulting disorders may not be intended, of course (our higher expectations of girls are not intended to make them sick, and the 'borderline' label is not intended to increase the convergence of difficult behaviors); but the results may be socially useful nonetheless. Social constructivists about hysteria, for example, have argued that hysteria provides a safe outlet for the frustrations of women who are systematically silenced or discounted in society at large -- an outlet that does not challenge the existing power structure and, indeed, may help to rationalize it.<sup>xviii</sup> Or, to take a very different sort of example: a diagnosis of neurasthenia, whatever its intent, often functioned to excuse various sorts of laziness and self-indulgence and sexual non-conformity on the part of wealthy young men in nineteenth century Europe.<sup>xix</sup>

The societal usefulness of such disorders often depends on its ability to disguise its own role in their creation, to foster the illusion of a natural rather than imposed convergence of symptoms. It is easier not to assign responsibility, easier (and more profitable) to pursue individual cures rather than systematic prevention, easier to distance oneself from the afflicted and accept a certain amount of madness as inevitable. (I say more about this in Section III.) But it is also a fact about the nature of perception and thought that we are better able to hold things together in our minds to the extent that we can 'see' or assume that they have an underlying 'nature'. So even if we can trace the social conditions that led to the regular co-occurrence of confusions about identity, manipulative social relations, affective instability, and self-destructive tendencies, it is extremely tempting, when we are actually confronted with this syndrome (so-called borderline personality disorder), to suppose that there is an underlying disease after all. Given the potential deceptiveness of this supposition, though, it is important to consider just how we can know whether a particular disorder is socially constructed or not.

## II

There are several types of evidence that, taken together, can support the claim that a mental disorder is socially constructed: evidence that there is no one biological or chemical condition responsible for the relevant array of symptoms, evidence that instances of the disorder (or alleged instances of the disorder) are closely correlated with specific societal conditions and interests, and evidence that alternative taxonomies are equally plausible. I will consider each of these types of evidence in turn, indicating some of the difficulties involved.

If the symptoms that we use to define a given disorder can be traced to a single biological or chemical condition -- to a genetic abnormality in the case of schizophrenia, for example, or to excessive serotonin uptake levels in the case of depression, for example -- then it is reasonable to suppose that both the disorder and our concept of the disorder should be explained by natural facts as opposed to social facts. Social factors might explain the distress that leads to certain genetic disorders, and social factors might explain our interest in certain syndromes rather than others, but the disorder itself will not be socially constructed since, in such cases, it will be nature, not society,

that is responsible for the relevant convergence of symptoms. (If one objects that the categories of genetics and chemistry are themselves socially constructed, we may ask: socially constructed as opposed to what? And: socially constructed out of what? Being a social constructivist about everything seems incoherent -- for much the same reason that being an antirealist about everything seems incoherent, but that argument is outside the scope of this paper.<sup>xx</sup>)

We do not have unified biological explanations for most mental disorders, however, and in many cases there is good reason to think that different instances of a disorder are correlated with quite different biological and chemical conditions. In the case of depression, for example, some instances of depression seem correlated with low levels of serotonin between synapses while other instances are clearly not. And in the case of schizophrenia, some sufferers have a family history that suggests a genetic component while others do not.<sup>xxi</sup> The most recent diagnostic manual of the American Psychiatric Association announces a rather conflicted position according to which, on the one hand, many diagnoses depend on ruling out organic factors (stipulating that if amphetamines are held to be responsible for one's delusions, the diagnosis should be "organic delusional disorder" rather than schizophrenia, and if a brain tumor is responsible for one's low mood, the diagnosis should be "organic mood disorder" rather than depression); but, on the other hand, we are assured that in the future "we may be able to identify specific organic factors that are responsible for initiating and maintaining these disorders".<sup>xxii</sup> The guiding thought, presumably, is that it is only 'abnormal' organic causes of the disorder that have been identified, and that the normal organic cause is yet to be found; but the more varied the identified causes turn out to be, the more one must doubt the existence of a more unified 'normal' cause.

If there is no one biological condition that underlies all (or most all) instances of a mental disorder, then it may well be that the disorder is a social construct -- a set of symptoms that has been brought together (in thought or in reality, or both) by a variety of social forces. But that is not the only possibility. Accounts of mental disorders that emphasize individual beliefs and desires (psychoanalytic explanations of depression that appeal to one's anger at what has been lost and one's narcissistic tendency to over-identify with what one loves, for example) are not social constructivist accounts insofar

as they locate the relevant causal factors within the individual rather than within the society at large. The distinction between individual factors and societal factors can be a difficult one, of course. Is it individuals who make their society narcissist or a society that makes its individuals narcissists? Do family dynamics (such as the Oedipal triangle) count as social dynamics, and are they the cause or the effect of larger cultural practices (concerning gender, for example)? But the social constructivist is committed to social explanations in contrast to both biological explanations and individual (psychological) explanations. So evidence against a biological basis for a given mental disorder is not yet evidence for a social basis.

This is where a second, historical type of evidence becomes important -- evidence of a correlation between certain social conditions and reported instances of the disorder in question. Hysteria, it seems, flourished in late nineteenth and early twentieth century Europe, especially among women. Charcot's hospital in Paris housed hundreds of (alleged) hysterics in the 1880s, yet now the diagnosis has practically disappeared. More recently, thousands of cases of multiple personality disorder were documented after the case of Sybil became famous in the 1960s, yet now the numbers seem to be diminishing. And there has been a virtual epidemic of attention deficit disorder among United States children, especially boys, since the 1980s. Whether these patterns reflect the rise and fall of actual syndromes or merely imagined syndromes (or syndromes that become actual because they are imagined), the absence of a common biological basis together with a strong correlation with specific historical conditions does suggest that these disorders are syndromes that have been created by societal conditions. And it is not hard to speculate on what some of these factors might be: the growing aspirations of women alongside the systematic repression of their sexuality, in the case of hysteria; a growing fascination with altered states of consciousness together with increased social service inquiries into childhood sexual abuse, in the case of multiple personality disorder; growing pressure to excel in school plus greater exposure to frantically paced media entertainment, in the case of attention deficit disorder.

It is of course possible that the symptoms of hysteria, of multiple personality disorder, and of attention deficit disorder converge with pretty much the same frequency in all societies; they may only be noticed more in some societies. It is hard to

eliminate this possibility given the difficulty of accessing the relevant data in historical cases, and given the difficulty of being an unbiased observer in cross-cultural cases. It would be unusual, though, for the prevailing diagnoses in a society to have no effect on the frequency of the syndromes in question (through the power of suggestion); and, more importantly, given the enormous number of regularities that *might* be noticed, society's focus on one set rather than another may itself be thought of as a kind of 'construction' -- a case of bringing some patterns rather than others into focus (much as a sculptor might bring out one preexisting form rather than another from a piece of marble).

The existence of equally plausible alternatives to the way we categorize mental disorders is, then, another type of evidence in favor of social constructivist accounts of those categories. For if two or more theories have equal empirical support, the choice between them must be made on other grounds, and social considerations provide one way to tip the balance in favor of one categorization rather than the other. (The balance might also be tipped with a coin toss, or on the basis of the idiosyncratic aesthetic preferences of an influential individual, but these are less likely options.) It is not so easy, however, to produce alternative taxonomies that have equal empirical support.<sup>xxiii</sup> It is not just a matter of inventing an amusing encyclopedia entry that divides animals into those that belong to the Emperor versus those that are embalmed, those that are tame versus those that are sucking pigs, those that are drawn with a very fine camelhair brush versus those that from a long way off look like flies, etc..<sup>xxiv</sup> To have equal empirical support, a given scheme must group things in ways that do in fact hang together in the sense that they tend to support lawlike generalizations and predictions. Animals that belong to the Emperor do not tend to look alike, do not behave in any special way, and are not necessarily capable of producing offspring with one another; surely there are more lawlike similarities between a pig that belongs to the Emperor and a sucking pig than between a pig that belongs to the Emperor and a bird that belongs to the Emperor.

Radical social constructionists are likely to respond: it all depends on what sorts of laws you are interested in. If the laws surrounding the handling of the Emperor's estate are more important to you than the laws surrounding the reproductive potential

of various animal pairings, then the above divisions will reflect more *relevant* lawlike generalizations; if not, not; and there is no interest-neutral way to compare the two. (This is where the traditional distinction between metaphysics, epistemology, and ethics can be seen to break down; rather than reality determining what we can know and what we hold valuable, what we hold valuable determines what we can know and what constitutes reality.) If this is right, though, then the alleged alternatives are not really alternatives after all; they are self-sustaining worlds that remain incommensurable.<sup>xxv</sup> And that means that they can no longer be used to provide evidence for the social constructivist thesis, for they no longer demonstrate the need for social factors to break an empirical impasse.

Less radical social constructionists, on the other hand, may prefer to argue for the empirical equivalence of different taxonomies simply by asking whether we are demonstrably better at predicting or curing mental disorders now than we were 100 years ago (when the prevailing taxonomy was quite different), or whether the categories and cures of contemporary American psychiatry have any better track record than those of traditional Chinese medicine.

### III

I turn, finally, to the practical implications of believing that mental disorders are socially constructed. What difference does it make if paranoia or schizophrenia, depression or anorexia, obsessive compulsive disorder or borderline personality disorder are created by society rather than by individuals or by biology?

Ian Hacking suggests that the crucial thing about a socially constructed category as opposed to a 'natural' category is that it is not inevitable, it can be changed.<sup>xxvi</sup> Change would be more or less difficult, though, depending on the sort of construction at issue. Insofar as it is the mere concept of a syndrome that has been constructed, that concept can probably be abandoned pretty much at will. (We might simply quit using the concept of 'borderline personality disorder', for example.) But insofar as an actual syndrome has been constructed by social conditions, those conditions would have to be altered in order for the syndrome to be eliminated. (Gender relations, advertising practices, and economic trends would need to change before anorexia disappears.)

Social conditions can be changed, of course, but social change is not necessarily easier than biological change. Delusions caused by brain tumors are more easily eliminated than delusions caused by childhood neglect, attention deficit disorder is more easily cured with Ritalin than by systematic changes in the education and entertainment industries, and it is certainly easier to take Prozac than to change the conditions that make one depressed. So knowing that a mental disorder is socially constructed may actually make it seem more rather than less inevitable.

Is it even desirable to eliminate socially constructed categories of mental illness? Surely we can't assume that all socially constructed syndromes are undesirable any more than we can assume that all naturally occurring syndromes are desirable. One can even imagine cases where a socially constructed syndrome helps one to deal with a more debilitating natural syndrome -- where obsessive-compulsive personality types counter the worst effects of a biologically-based tendency towards depression, for example.<sup>xxvii</sup> As with all medical or psychological interventions, the desirability of certain social interventions will depend on what would be gained and what would be lost if a certain disorder were eliminated, and just what the alternatives are.

Should we at least abandon the mental disorder concepts that do not reflect lawlike regularities -- concepts that group disconnected experiences and behaviors together to produce the *illusion* of a syndrome? Again, it depends on the costs and benefits and it depends on the alternatives. The concept of borderline personality disorder, for example, may be very useful for indicating a diverse set of experiences and behaviors that psychiatrists have trouble understanding -- especially if some such label is crucial for receiving insurance benefits; abandoning it, in the absence of better alternatives, would probably be a mistake.

Still, recognizing the socially constructed character of a particular syndrome or concept does help to dispel the illusion of naturalness, and dispelling the illusion of naturalness should encourage us to at least consider the social factors involved and the alternatives they suggest. Might an alternative school environment and restrictions on television entertainment be a better alternative than Ritalin? Might immersion in a new project or profession be an alternative to Prozac? And so on. Simply considering such

alternatives will tend to make us less passive in our dealings with disorder: less willing to turn decisions over to medical or psychiatric authorities, more willing to imagine radical alternatives, and more attentive to our own contributions to the problem.<sup>xxviii</sup>

Finally, it has been suggested -- rightly, I think -- that social constructivism about mental disorders results in a tendency to abandon any attempt to reach a consensus about which diagnostic categories to use.<sup>xxix</sup> If there is no objective ordering of experience and behavior for our categories to capture, then there is no more reason for us to agree about how to categorize mental disorders than there is for us to agree about how to categorize contemporary art, or how to categorize different types of beauty. This does not mean that anything goes; some ways of categorizing will be more useful for some purposes, others for other purposes. But if a category is socially constructed there is no reason for people with different interests to try to achieve consensus about which scheme of categories to use.

Is abandoning the attempt at consensus a good or a bad thing? It is a bad thing if it discourages scientific research and debate that would lead to the discovery of the underlying 'natures' of various mental disorders; but such a complaint clearly begs the question: we can only expect to discover the underlying nature of a mental disorder if we expect that it has one -- which is precisely the assumption that the social constructionist rejects. It might also be a bad thing if it leads to types of disagreement and strife that cause those who suffer to suffer even more -- because their troubles fail to be recognized as such by doctors, or in courts, for example. Or it may be a good thing insofar as it encourages sufferers to greater participation in their own diagnoses and cures.<sup>xxx</sup> Whatever the tradeoffs, however, they will be purely pragmatic tradeoffs if social constructivism is correct -- if there is no independent reality to get right.

In conclusion, then, there is no reason to suppose that a socially constructed mental disorder is easier to change than a naturally constituted mental disorder; and until one considers the situation-specific alternatives, there is no reason to suppose that change is even desirable. There is, however, reason to think that believing that a mental disorder is socially constructed will tend to elicit more imaginative and more responsible responses from us; and that it will make us less inclined to seek consensus.

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ENDNOTES

<sup>i</sup> Just how popular it has become is made vivid in the opening pages of Ian Hacking [1999], where he lists a wide range of book titles describing things as socially constructed.

<sup>ii</sup> Michel Foucault's Histoire de la Folie was published in France in 1961, a year after Thomas Szasz's paper "The Myth of Mental Illness" was presented to the American Psychological Association. Subsequently, Foucault's book was translated into English as Madness and Civilization [1965] and Szasz published his book The Manufacture of Madness [1970].

<sup>iii</sup> Evolutionary accounts of madness may also emphasize the importance of social factors, but only insofar as such factors have managed to modify our genetic makeup (over many centuries). The social constructivist focuses on more variable societal forces, acting on us in the present.

<sup>iv</sup> There is a continuing controversy, within philosophy and within the social sciences more generally, over whether social causes must ultimately reduce to psychological causes, and whether psychological causes must ultimately reduce to physical causes. This controversy turns, in part, on whether the causes in question admit of multiple 'realizations' (i.e. whether the same social problem, for example, may be realized by individuals with quite different psychologies, and whether the same psychological problem may be realized by quite different neurologies); and if multiple realizability is a possibility, whether that stands in the way of reductions or not. (The recent work of Jaegwon Kim is particularly useful on this topic.) Social constructivists, though, are committed antireductionists.

<sup>v</sup> This is a central theme in Peter Stallybrass and Allon White's influential book The Politics and Poetics of Transgression [1987].

<sup>vi</sup> The listed experiences and behaviors are the main indicators of anorexia and of borderline personality disorder according to the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders: DSM-III-R [1987].

<sup>vii</sup> Foucault, for example, uses Borges' list of things that fall under a single Chinese term to suggest that there is no such thing as a natural grouping of properties, only

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groupings that seem natural within some cultural or linguistic context -- and unnatural within another (opening page of the Preface to The Order of Things: An Archeology of the Human Sciences [1970]). I question the ultimate coherence of this view in Section II.

<sup>viii</sup> Preexisting unities include natural kinds, in which a variety of experiences and behaviors has a single underlying cause, and natural conglomerates, in which there is no single underlying cause (a physiological imbalance, for example) but there are reliable causal connections between the symptoms (anxiety tending to cause obsessiveness and obsessiveness tending to cause anxiety, for example). Within medicine, and within contemporary psychiatry, the first is usually called a disease, the second a mere syndrome. If the relevant behaviors form a preexisting unity of either sort, they are not socially constructed.

<sup>ix</sup> According to Ofshe and Watters [1994], multiple personalities emerge, on average, seven years into therapy!

<sup>x</sup> This is a list of personality disorders cited in DSM-III-R [1987].

<sup>xi</sup> Ian Hacking [1999], p.109.

<sup>xii</sup> Ian Hacking [1999], p. 110.

<sup>xiii</sup> As both Foucault and Szasz are fond of pointing out, mental disorders have been variously treated as instances of demonic possession, as indications of inspired madness, and as forms of medical illness. The different associations that characterize each of these conceptualizations are part of what make them different social constructions.

<sup>xiv</sup> The opponent of social construction at this level must argue that there is an objective basis for drawing the line between normalcy and madness one way rather than another -- on the basis of natural functions, perhaps. (There was a lively discussion of this possibility in several contributions to the journal *Philosophy, Psychiatry, and Psychology*, vol. 5, 1998.) But if the critical functions are social functions, and if what is functional in society is highly variable between societies, it is hard to resist the conclusion that madness as such is socially constructed.

<sup>xv</sup> p. xxii, Introduction to DSM-III-R.

<sup>xvi</sup> This is one way to interpret the observations reported by anthropologist Jean L. Briggs [1970].

<sup>xvii</sup> Anthony David [1999], for example, argues that the concept of a delusion is really just a societal marker for whatever assortment of beliefs and images are discredited in that society. R. W.M. Fulford [1994] also details various difficulties in determining what counts as a delusion.

<sup>xviii</sup> Recent books that explore analyses along these lines include Bernheimer and Kahane [1995], Micale [1995], and Showalter [1997].

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<sup>xix</sup> Note that this is a case of mental disorder but not of madness or insanity -- a disorder that is valued (as conducive to artistic sensitivity and creativity) rather than disvalued.

<sup>xx</sup> Paul Boghossian has published a number of articles that address these problems, especially [2001].

<sup>xxi</sup> The fact that no single drug works dependably to relieve symptoms of depression or schizophrenia is also indirect evidence against a unified biological basis for either.

<sup>xxii</sup> p. 23, DSM-III-R.

<sup>xxiii</sup> It is not individual diagnoses but the taxonomy of a field that is at issue here. The fact that it is sometimes equally plausible to categorize someone as paranoid as to categorize her as schizophrenic only indicates fuzzy boundaries, it does not show that there are equally plausible alternatives to the prevailing categorical scheme.

<sup>xxiv</sup> The list is that of Michel Foucault (following Borges), at the opening of his Preface to The Order of Things [1970].

<sup>xxv</sup> Thus, Nelson's Goodman's willingness to embrace the existence of many different worlds, in Ways of Worldmaking [1978].

<sup>xxvi</sup> p. 6, Hacking [1999]. In this and other passages of his book, Ian Hacking seems to treat causation by individual beliefs and desires as a case of social construction. At least within psychology and psychiatry, however, it is important to distinguish the two; otherwise psychoanalysis, for example, will turn out to be a form of social constructivism.

<sup>xxvii</sup> If all categories are socially constructed, this contrast doesn't even make sense, of course; but I shall continue to assume that it does.

<sup>xxviii</sup> Thomas Szasz has long argued that mental illness is a myth designed to disguise the social origins of various "problems of living" and their various "solutions". And this myth, he argues, has allowed us both to deprive people of liberty when they are guilty of no crime and to excuse people of responsibility when they are guilty of crimes. (See, most recently, Szasz [1998].) Should a social constructivist about mental disorders, then, object to involuntary incarceration and to insanity pleas in criminal court? This conclusion, I think, confuses social responsibility with individual responsibility; if societal forces are responsible for making an individual delusional, then society may also be responsible for minimizing the ill effects of those delusions and for accepting responsibility for the ill effects that do occur.

<sup>xxix</sup> Eric Gillett [1998], for example, complains that "constructivist relativism undermines the search for consensus achieved through scientific debate."

<sup>xxx</sup> The importance of self-determination, within a liberal society, is discussed in connection with multiple personality disorders, by Jennifer Radden [1996], esp. pp. 220-226.

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