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Binary Oppositions in Psychiatry: *For or Against?*

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In their interesting and informative paper 'From Szasz to Foucault: On the Role of Critical Psychiatry,' Pat Bracken and Phil Thomas contrast, in a clear and helpful way, some central themes in the works of Thomas Szasz and Michel Foucault. They go on to endorse a form of critical psychiatry inspired by the latter. Szasz's critique of psychiatry, they explain, is premised on binary oppositions, principally that between 'mental' and 'bodily.' Szasz begins by assuming the legitimacy of the distinction and proceeds to argue that the term 'illness' can only be legitimately applied to what is 'bodily.' According to Szasz, there are medical pathologies, which are to be understood in naturalistic, biological terms, and there are also 'problems in living,' which should not be conceived of in that way. Bracken and Thomas then show how Foucault's work challenges this kind of view, by exposing the historical contingency of the discourses, practices and ideologies in which binary oppositions such as that between 'mental' and 'bodily' are embedded. Having contrasted the two approaches, they conclude that Foucault serves as the better role model for current critical psychiatry. Psychiatry, they propose, should strive to make explicit the contingency of its concepts and practices, opening up not just new positions within an already established arena of debate but also new possibilities for debate.

I sympathize with much of what Bracken and Thomas say. However, there is perhaps a tension in their critique of arguments that work by contrasting A with B and then rejecting B, given that their own argument proceeds by contrasting Foucault with Szasz and then rejecting Szasz. In what follows, I question the assumption that a Szaszian mental/bodily contrast and a Foucaultian critical project have to be incompatible. Of course, Szasz and Foucault part company in many ways. For instance, their political views are quite different. But thinking in terms of an opposition between 'mental' and 'bodily' does not require prior endorsement of a specific political position (although I do not rule out the possibility that it is symptomatic of deeper forms of social organization that are presupposed by superficially divergent political positions). One conciliatory strategy, I suggest, is to maintain that Szasz and Foucault are involved in different kinds of project and that the mental/bodily opposition is legitimately assumed in the context of one project even if not the other.

Having raised this possibility, I go on to argue that a *strict* contrast between 'bodily' and 'mental' illnesses, or between 'bodily' illnesses and 'mental' problems in living, should indeed be rejected, regardless of which project one is involved in.

Drawing on the work of the phenomenologist and psychiatrist J. H. van den Berg, I briefly indicate how both 'bodily' and 'mental' illnesses can involve profound shifts in the patient's experience of the world and in her relations with other people. In fact, the 'mental' and 'bodily' symptoms of an illness are sometimes one and the same, and so a line between mental and non-mental kinds of illness cannot be clearly drawn. Nevertheless, I conclude by shying away from complete rejection of the distinction between mental and non-mental illnesses, suggesting instead that it can be retained in a pragmatic role.

Overcoming Binary Oppositions

Although Bracken and Thomas focus on the mental/bodily opposition, there are plenty of closely related distinctions at play in philosophy, psychology, psychiatry, and elsewhere, including internal/external, mental/physical, subjective/objective, cognitive/affective, mind/body, and psychological/non-psychological. They all have slightly different connotations and so it is important not to use them interchangeably. In addition, it is frequently unclear what is meant by them. For instance, a mental/bodily contrast might be employed to characterize substance dualism, but it might also be used by a non-dualist to distinguish between psychological and non-psychological aspects of a person. Hence, in recommending that the contrast be rejected, there is a need to be clear about what exactly is to be rejected. Furthermore, there are different ways in which one could be said to *oppose* a binary opposition. Bracken and Thomas recommend that we work to "overcome" them, stating that "a great deal of human suffering demands that we think beyond binaries" (2010, 223). They also refer to the "destructive impact of ordering the world in terms of simple binary distinctions such as good/bad, right/wrong, truth/ideology, illness/non-illness" (2010, 226). There are various ways of interpreting their position with respect to the mental/bodily distinction, some stronger than others. Here are four options:

1. It is never fruitful to think in terms of the mental/bodily distinction.
2. It is sometimes fruitful to think in these terms, but we should do so less often.
3. It is fruitful to think in these terms in certain specific contexts but not in others.
4. There is no problem with employing the mental/bodily distinction, but we need to think in other ways, too.

Of the above, only 1, 2, and 3 are critical of the distinction. Each of these can be further subdivided into different kinds of complaint. For instance, one might object to a metaphysical view that is explicitly or implicitly associated with the distinction in some or all of its uses. The strongest version of the metaphysical complaint would be that the distinction is never true of the world in any of its metaphysical guises. But, even if this were the case, the distinction might still be a *useful* one to draw on occasion. Hence, it could be defended on pragmatic grounds rather than altogether abandoned.

So what exactly does "overcoming" the opposition involve? On one interpretation of Bracken and Thomas's position, we recognize that metaphysical distinctions between mental and non-mental properties of human beings are dependent upon historically and culturally contingent sets of discourses and practices. In so doing, we come to appreciate the contingency of what we previously took for granted. This would not require rejecting the distinction. By analogy, consider a person who thinks that the whole world speaks English and then visits France for the first time. When she returns to England, she has a new appreciation of the contingency of her language, which may well alter her behaviour in at least some situations. However, it has no implications for her daily routine of going to the shop and asking in English for the latest newspaper. After her enlightenment, things carry on much as before. Bracken and Thomas remark that:

> Foucault is sceptical of binary distinctions. He does not position psychiatry as something bad, or wrong, but instead shows that its history is not a necessary one, that is, something that simply had to develop the way it did, according to a logic that is independent of particular human interests. (2010, 223)

The claim that something did not have to arise in exactly the way that it did does not imply that

it ought to be rejected or even that it is in any way problematic. Granted, recognition of contingency is a first step en route to the formulation of alternatives. But the possibility of critique need not entail actual critique, and actual critique need not entail full-scale rejection. Indeed, it is worth noting that Bracken and Thomas themselves use the terms "mental distress," "mental health work," and later "mental suffering" without scare quotes. This might suggest that their aim is not to ditch such language altogether but to awaken a sense of intellectual humility, a realization that categories which structure much of our current thinking are specific to contingent and easily overlooked sociocultural practices. So perhaps there is still room for both approaches: Szaszian anti-psychiatry arguments might be formulated in the context of certain practices that other forms of enquiry reveal to be contingent. This view does not entail acceptance of Szasz's critique. The mental/bodily distinction is separable from the medical/non-medical distinction and one could thus reject Szasz's application of the latter to the former, as Bracken and Thomas do, without rejecting the former in the process.

I also wonder whose responsibility it is to reveal the historical and cultural contingency of binary oppositions between psychological and non-psychological characteristics. This would be asking a lot of the psychiatrist, even a radically reconceptualized kind of psychiatrist. The required critique is concerned with forms of thinking that encompass much more than just psychiatry. Furthermore, the task of bringing historically entrenched presuppositions to light demands a kind of training that differs markedly from medical training and is perhaps closer to that of certain kinds of philosopher, historian, or anthropologist. If one of the psychiatrist's responsibilities is to offer this kind of critique, then the boundaries between psychiatry and a range of other disciplines become unclear. Bracken and Thomas state that a "fundamental question that faces psychiatry" is whether there can be a discourse that is "adequate to" the realities of human suffering (2010, 222). But any discourse that did full justice to the many aspects and variants of human suffering would have to incorporate a wide range of academic disciplines and much else besides. Psychiatry alone, even if conceived of in a very different and permissive way, could not accommodate all of that. So let us assume that there is to be at least some differentiation between the responsibilities of different intellectual discourses and practices, rather than the complete loss of a discernable discipline called 'psychiatry.' Conceding even this much allows for the possibility of psychiatry accepting binary oppositions that other practices scrutinize.

However, it is clear that there is more to critical psychiatry than reminders of contingency and pleas for humility. In the conclusion to their article, Bracken and Thomas mention three principal tasks with which critical psychiatry is currently concerned: criticizing the influence of the pharmaceutical industry on psychiatry, trying to set up a form of medical discourse that better engages with human "mental suffering," and consolidating links with the user/survivor movement. I assume that such projects can be pursued at least to some extent from 'within' the conceptual frameworks of current psychiatry. It is debatable whether and to what extent they must depend on the uncovering of historically entrenched presuppositions that shape much or all of current Western thought. Bracken and Thomas remark that "what is most evident to us as doctors is that we do not *suffer* in the world in two different modes: bodily and mental" (2010, 222). I agree, and it is worth noting that they recognize this *as doctors*. To some degree at least, the shortcomings of the distinction between mental and bodily illnesses are evident even from *within* the current medical profession.

The World of Illness

Reference to different kinds of *suffering* suggests that Bracken and Thomas are conceiving of the mental/bodily distinction as a phenomenological distinction, given that 'modes of suffering' are suggestive of 'ways of experiencing.' In the remainder of my discussion, I will also understand it in this way, and will suggest that we do not need to dig as deep as Foucault in order to appreciate that a contrast between 'mental' and 'bodily' is often uninformative and unhelpful. The contrast is, I think, partly symptomatic of a failure to ad-

equately attend to the phenomenology of illness. In short, what phenomenological study consistently shows is that experiences of 'mental' and 'bodily' symptoms cannot be cleanly separated. Indeed, these symptoms are frequently one and the same. To illustrate this, I will focus on two works by the brilliant but neglected phenomenologist and psychiatrist J. H. van den Berg, one of which offers a phenomenological description of what we might call 'mental' illness whilst the other addresses 'bodily' illness. What the comparison shows, I will suggest, is that certain popular misconceptions of the mental apply to neither case, and that other conceptions of the mental apply equally to both.

Van den Berg's book *A Different Existence* is inspired partly by Sartre's phenomenology. Like Sartre, he proposes that the psychological does not manifest itself as some kind of 'internal mental state' that psychiatric patients can access via introspection and then describe without reference to experiences of their bodies and surrounding worlds. According to van den Berg, once any changes in experience of body and world have been described, there is no psychological, internal or subjective residuum left to account for:

> To express a strictly subjective complaint, a complaint pertaining to the subject and not to the body or its environment, is beyond our powers. He who complains, complains about things there, in the body or in the objects there. (Van den Berg 1972, 44)

Having rejected the idea of an internal phenomenology that is set apart from experience of body and world, van den Berg proceeds to offer a description of the 'typical' psychiatric patient. In so doing, he stresses that anomalous bodily experiences are not *projected* onto the experienced world. Rather, changes in bodily experience are inextricable from changes in world experience; they are one and the same: "When the psychiatric patient tells us what his world looks like, he states, without detours and without mistakes, what he is like" (1972, 46). We do not experience the world as a neutral, detached realm of spatiotemporally located objects. Instead, the world that we typically take for granted in our everyday lives is a place where things are experienced as mattering to us in a range of different ways. We do not first of all perceive neutral objects and afterwards infer their significance. Instead, the world as perceived is saturated with significance: "We might say that we see the significance things have for us. If we don't see the significance, we don't see anything at all" (Van den Berg 1972, 37). Our bodily phenomenology is inseparable from the perceived significance of things, given that perception of significance depends upon a range of bodily dispositions. We do not experience these dispositions as *objects* of awareness though, but as the possibilities that the world has to offer. We perceive the significance of things *through* our dynamic, feeling bodies. Consequently, certain marked changes in bodily awareness that typify psychopathology, especially changes in overall bodily awareness, are also changes in how the person experiences and relates to her surroundings. There is a shift in the sense of being comfortably at home in a meaningful world, and this is intimately associated with altered bodily awareness. As van den Berg remarks:

> His world is collapsing. Is he not saying the same thing when he states that his legs are failing him and he feels he is losing the sense of equilibrium! *World* and *body* are interrelated. Then the customary distinction of *world* and *body* is probably much too definite. (1972, 56)

Even 'thoughts,' van den Berg says, occur in the context of a pre-experienced world; when there is something wrong with our thinking, the world does not seem quite right either. So thought is not simply 'internal,' but founded upon the prior phenomenological achievement of having a world, which is itself inseparable from our bodily phenomenology. Hence we should not think of the 'psychological' or 'mental' primarily in terms of processes that are phenomenologically located inside our heads but, rather, in terms of the body–world relation.

Van den Berg adds that changes in the structure of our relations with each other are central to psychiatric illness. Other people affect our bodily experience in a wide range of ways and can, in so doing, transform how we experience a scene or the extent to which we find ourselves at home in a place (think of Sartrean shame, for example). Indeed, he concludes that "loneliness is the nucleus of psychiatry" (1972, 105), an estrangement from others that is at the same time a change in bodily experience and a diminishment of world.

Are the kinds of bodily change that van den Berg describes specific to what are commonly referred to as *mental* illnesses, thus respecting a phenomenological distinction between two distinct categories of illness? His answer would seem to be no, as exemplified by *The Psychology of the Sickbed*. In this short essay, van den Berg attempts to articulate the phenomenology of illness more generally. He addresses the predicament of the chronically ill patient with little change of recovery, but at the same time makes clear that the analysis is not intended to apply exclusively to such cases. As with psychiatric illness, van den Berg claims that serious illnesses more generally involve changes in the overall shape of world experience, where kinds of significance and possibility that were previously unthinkingly presupposed are now lost or threatened: "One suddenly becomes uncertain about things taken most for granted" (1966, 38). There is, he says, a feeling of estrangement from others, and an associated loss of the comfortable sense of belonging to a world that typifies much healthy experience. A world that was previously filled with countless possibilities for effortless activities has somehow contracted. An orientation towards salient future possibilities, a sense of projects and goals in the light of which experienced entities and people appeared significant in various ways, is suspended. Hence one becomes rooted in a restrictive 'here and now.' All of this is intimately bound up with changes in the body. The healthy body is experienced primarily as a system of opportunities that the world presents, rather than as a thing from which one distinguishes oneself: "The healthy person is allowed to *be* his body and he makes use of this right eagerly: he *is* his body." Illness, van den Berg says, "disturbs this assimilation. Man's body becomes foreign to him" (1966, 66). He also emphasizes that experience of illness is inseparable from changes in the patient's relations with others. Visitors to the sickbed do not generally manage to leave their own world behind so as engage with the patient's predicament, and instead continue to talk of a life that for the patient is gone. In other words, they continue to presuppose systems of significance that the patient has left behind. They therefore exacerbate an already pronounced sense of alienation from the social world.

Of course, there is no single, universal 'phenomenology of illness,' and matters are further complicated by the fact that experience of illness is influenced to a considerable degree by factors including personal and interpersonal circumstances, medical intervention, idiosyncratic dispositions, and contingent cultural attitudes. Even so, analyses such as van den Berg's at least serve to emphasize that estrangement from others, and a more general loss of experienced belonging, are common to various illnesses and not just those that tend to be labeled as 'mental.' Sometimes, a 'bodily' illness will be causally associated with distinct complaints that are labeled as 'psychological' but, on some occasions at least, the psychological and the bodily cannot be separated; changes in bodily experience are at the same time profound changes in how one experiences and relates to the world and to other people. As van den Berg's emphasis on the interpersonal aspects of illness serves to illustrate, to view a person's complaint as a merely 'bodily' illness and not to engage with her changed world in any way can be just as alienating as certain commonplace attitudes toward 'mental' illness. At least some of the 'problems in living' that are experienced by patients cannot be cleanly separated from illness and a failure to understand these problems from the person's perspective can surely be detrimental to the treatment of illness.

The phenomenological claims that I have drawn attention to here are not specific to van den Berg's work. The inextricability of bodily experience and world experience is a consistent theme in the phenomenological tradition, as exemplified by the later work of Edmund Husserl and its re-interpretation and further development by Maurice Merleau-Ponty. (See my *Feelings of Being* for a detailed discussion of the phenomenological inextricability of body and world.) Husserl, Merleau-Ponty, and others emphasize that bodily experience does not simply consist in the explicit awareness of a static body-object. They describe a background sense of one's dynamic body as a locus of agency and possibility, a bodily receptivity that is intertwined with how one experiences one's situation. Other, more recent authors have further emphasized the dynamic aspects of bodily awareness and their inextricability from world experience and thought. For instance, Maxine

Sheets-Johnstone (1999/2009) offers a detailed phenomenological analysis of an improvised dance, stressing how we think and experience the world *through* bodily movement. There is, she says "no mind doing' that is separate from a 'body-doing'" and adds, "to separate myself into a mind and a body would be to perform a radical surgery on myself such that a vibrant kinetic reality is reduced to faint and impotent pulp, or excised altogether" (2009, 32). World experience and bodily movement here are part of one and the same process. In addition to this, much of the dancer's thinking does not arise in a way that is 'outside' or separable from actual and anticipated bodily movement.

Many psychiatric complaints are characterized by a loss of just this kind of spontaneous, intelligent, dynamic engagement with an interpersonal situation. Severe depression, for instance, tends to involve a diminishment or loss of the practical familiarity of things, coupled with loss of spontaneous and effortless affective interaction with others. Along with this, the body becomes cumbersome, conspicuous, and often painful, quite unlike the body that is seamlessly immersed in an activity and reflected in the possibilities that a situation is perceived as offering (see Ratcliffe [2009], for a discussion of the phenomenology of depression). Here too, body and world are phenomenologically inseparable. The kind of bodily conspicuousness that characterizes depression is phenomenologically inextricably from a world that is bereft of practical significance, from which one feels strangely cut off. It is also implicated in changed interpersonal relations; a pervasive sense of bodily conspicuousness and awkwardness is at the same time a loss of effortless, spontaneous interpersonal interaction.

Are There 'Mental' Disorders?

What I have said in the last section is very much in agreement with Bracken and Thomas's opposition to a phenomenological mental/bodily distinction. However, this need not imply that there is no room left for the category of 'mental' disorder. The issue is complicated by the fact that there are different definitions of 'mental disorder.' For example, there is an important contrast between what Radden (2003) calls "ontological descriptivism" and an etiological approach, where the former identifies the disorder with observable symptoms as described by the DSM or some other diagnostic manual, and the latter identifies it with the underlying cause of these symptoms. But phenomenological critique has implications for both kinds of account, and indeed for any account that does not completely disregard the nature of the relevant experiences, as it calls into question whether there is even such a category as 'mental symptoms.'

However, although the distinction between mental and non-mental symptoms is both blurred and in some circumstances misleading, it remains helpful when distinguishing illnesses where the most troubling aspects of the experience (for the patient or for others) take the form of altered bodily awareness from others where the most troubling aspects are changes in world experience, thought, relations with others or perhaps sense of self. If a distinction between 'psychological' and 'non-psychological' illnesses or between 'psychological' and 'non-psychological' symptoms is used in this way, it strikes me as fairly benign. "My body is causing me pain" and "I can't do certain things because of my body" would fall into one category, whereas "I feel like an automaton and the world looks oddly unreal" would fall into the other. Body and world are phenomenologically inextricable, like two sides of a coin, but one or the other side of the coin may be the most salient source of concern or discomfort in a given case. Hence a *psychological/non-psychological* distinction can serve to indicate what it is that is most troubling. (That said, I think that a contrast between the 'mental' or 'psychological' and the 'bodily' is best avoided. Regardless of whether it is employed phenomenologically or in some other way, the psychological is not to be opposed to the 'bodily.') This is not an absolute distinction, but a pragmatic one, and there will be plenty of cases that do not fall neatly into one or the other category. If oppositions such as psychological/non-psychological are used like this, to make rough and ready distinctions that serve as steps en route to more refined understandings, diagnoses

and treatments rather than to forge an ontological distinction between two separate realms of illness, then I have no objection to them. Of course, that still leaves us with the question of what it is that makes something an 'illness.'

References

Bracken, P., and P. Thomas. 2010. From Szasz to Foucault: On the role of critical psychiatry. *Philosophy, Psychiatry, & Psychology* 17, no. 3:219–228.

Radden, J. 2003. Is this dame melancholy? Equating today's depression and past melancholia. *Philosophy, Psychiatry & Psychology* 10:37–52.

Ratcliffe, M. 2008. *Feelings of being: Phenomenology, psychiatry and the sense of reality*. Oxford: Oxford University Press.

Ratcliffe, M. (2009). Understanding existential changes in psychiatric illness: The indispensability of phenomenology. In *Psychiatry as cognitive neuroscience*, ed. M. Broome and L. Bortolotti, 223–44. Oxford: Oxford University Press.

Sheets-Johnstone, M. 1999/2009. Thinking in movement. In *The corporeal turn: An interdisciplinary reader*, ed. M. Sheets-Johnstone, 28–63. Exeter: Imprint Academic.

Van den Berg, J. H. 1966. *The psychology of the sickbed*. Pittsburgh: Duquesne University Press.

———. 1972. *A different existence: Principles of phenomenological psychopathology*. Pittsburgh: Duquesne University Press.