Medicating the Eschatological Body:

Psychiatric Technology for Christian Wayfarers

by

Warren Anderson Kinghorn

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Approved:

Prof. Stanley Hauerwas, Supervisor

Prof. Paul Griffiths

Prof. Reinhard Huetter

Prof. Keith Meador

Prof. Allen Verhey

Dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Theology in the Divinity School of Duke University

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ABSTRACT

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Biological psychiatry, the mode of psychiatric practice dedicated to the effective application of medication and other somatic technology in the treatment of mental disorders, is an increasingly powerful conceptual lens by which disfavored experience and behavior is interpreted and through which the relationship of the body to experience and to moral agency is narrated. Psychiatric medications and other forms of psychiatric technology are commonly used by and increasingly accepted within the American population, and biological psychiatry has become the dominant political and methodological force within American psychiatry. Christians writing about psychiatry have often either uncritically accepted the language of biological psychiatry or have deferred judgment to those with expertise in the biomedical model. In this dissertation I argue that the use of psychiatric technology, while often helpful and necessary, is pervaded with ethical and teleological commitments which demand critical theological analysis if Christians are to use psychiatric technology appropriately. I also present the theological anthropology of St. Thomas Aquinas as a conceptual resource for constructive Christian engagement with biological psychiatry and psychiatric technology.

After an introductory chapter (Chapter 1) which surveys the way that five contemporary American Christian communities of discourse engage biological psychiatry, the dissertation is divided into two methodologically distinct parts. Part One, comprising Chapters 2-5, is a philosophical engagement with contemporary psychiatric practice which shows that contemporary psychiatry both displays and requires ethical and
teleological commitment. In Chapter 2, I argue that appropriate application of psychiatric technology cannot be specified by neurobiology alone; one must, in addition, have a model for disease classification, or nosology, which specifies instances of “mental disorder.” Critical engagement of psychiatric technology therefore requires critical engagement of the nosologies which legitimate the use of such technology. I briefly review the history of American psychiatric nosology as it has evolved within successive editions of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) and survey rival contemporary philosophical accounts of “mental disorder.” In Chapter 3, I engage Alasdair MacIntyre’s threefold typology of versions of moral enquiry to argue that psychiatric nosologies, including the DSM, should be understood not in “encyclopedic” mode but rather as tradition-constituted forms of discourse. In Chapter 4, I argue that psychiatric diagnosis displays particular commitments regarding human teleology and also that any nosology adequate for clinical practice must be able to demarcate medical from non-medical failures of flourishing. The DSM ultimately fails at both because it necessarily displays teleological commitments and yet, situated within a late-modern culture lacking shared agreement about ends, it cannot name these commitments in sufficient detail to render its nosology coherent and therefore to demarcate the medical from the non-medical. In Chapter 5, I use the example of Post-Traumatic Stress Disorder (PTSD) to argue that psychiatric diagnosis is important not only because it legitimates the use of particular forms of psychiatric technology but also because it can construct the experience, and therefore the experiencing self, of those who receive and accept particular diagnoses.
Part Two, comprising Chapters 6 through 9, presents the theological anthropology of St. Thomas Aquinas as a helpful conceptual resource for Christians seeking to discern appropriate applications of psychiatric technology in the face of the aforementioned limitations of contemporary psychiatric nosology. In Chapters 6 and 7, I describe several contours of Aquinas’ theological anthropology, arguing that Aquinas provides not only a nuanced and non-individualistic account of the relation of body and soul but also a means for contextualizing technological modification of the body within the larger structure of a well-lived life. In Chapter 8, I detail Aquinas’ account in the *Summa theologiae* of the relationship between the body and personal moral agency and argue that the “health” of the body must be understood recursively, in the context of the virtuous operation of the person. In Chapter 9, I present a formal model of how Christians might discern appropriate uses of psychiatric technology. If close consideration of the moral-teleological context reveals that psychiatric technology might be justified, I argue that psychiatric technology may be used to the extent that it helps, and does not hinder, the embodied person’s participation in the life of virtue. These decisions, however, require habituation into the virtue of prudence and require consideration of the communal-political context within which particular teleological judgments are intelligible.
To Susan
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1 ‘Biological Psychiatry’ and Its Christian Interlocutors

Psychologist Paul Vitz opens the second edition (1994) of his 1977 theological polemic against modern psychiatry and psychology, *Psychology as Religion: The Cult of Self-Worship*, with the following characterization of “psychology:”

As the title [of the book] suggests, it will be argued that psychology has become a religion: a secular cult of the self. By this I mean an intensely held worldview, a philosophy of life or ideology. More specifically, contemporary psychology is a form of secular humanism based on the rejection of God and worship of the self.¹

At the time of its initial publication in the late 1970s, Vitz’ book gained cautious but favorable critical attention in the theological academy. Clinton W. McLemore, writing in the *Journal of Pastoral Care*, stated that as a result of Vitz’ argument “it may be time to question our nearly ubiquitous folk religion” and predicted that it is “likely to send shock waves through the intellectual community to which it is addressed.”² Peter Van Katwijk, writing in the *Calvin Theological Journal*, while lamenting Vitz’ incautious polemic, called it a “frontal attack on the scientific aura surrounding today’s psychology.”³

When Vitz’ book was reissued in 1992, it was received very differently by a reviewer of the *Calvin Theological Journal*:

The first edition of *Psychology . . .* (1977) was widely praised and sold exceptionally well. It was seen as a pioneering though polemical warning about the nature and influence of psychology . . . But this edition seems disappointing.

Since 1977 much has changed about psychology, its popular expressions, and influence . . . This edition adds little to the first and seems as dated as the first was ground-breaking.4

Vitz himself, starting in the aforementioned introduction, acknowledges fundamental changes within psychology, and finds much to celebrate in these changes.

In the context of a 2005 *apologia* for “positive psychology,”5 Vitz states that

Psychology has become much more humble over the past thirty years. And this has happened for several reasons. First, psychiatry and the biological sciences have made important new contributions to therapy, so that today people suffering from depression, obsessions, and many other psychological problems take medication, which tends to be more effective, immediate, and cheaper than long-term therapy (despite the complications and side-effects that medications can cause). Second, . . . the majority of psychologists have now recognized . . . that although psychotherapy is helpful, it rarely provides life-transforming insight or happiness. As a result, many psychologists themselves moved off into spirituality and religious experience as a more successful form of healing . . . Health care practice has also forced psychology to confront itself and to revise its self-understanding. Managed health care has made it difficult for patients to have long-term psychotherapy, as insurance companies will only pay for short-term therapy, [which] tends to be a kind of pragmatic cognitive/behavioral therapy, without the grandiose theoretical ambitions of the first psychological systems.6

This brief anecdotal look into the reception of *Psychology as Religion* across the last three decades, and into the evolution of Vitz’ own views, makes clear that the landscapes of American psychology and psychiatry (themselves, as I will argue later, interdigitated but distinct disciplines) have dramatically and inalterably changed during that time. The humanistic self-psychologists who attracted Vitz’ vitriol in 1977 are, however influential in the practical-theoretical background, generally unread and often

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5 Positive psychology is a recent movement within psychology (so far of little influence on psychiatry or psychiatric practice) to orient both experimental psychology and psychotherapy less toward examination of pathology and more toward examination of human strengths. See Martin A. Seligman and others, “Positive Psychology Progress: Empirical Validation of Interventions,” *American Psychologist* 60 (2005): 410-21.

largely disregarded by contemporary psychological and psychiatric students and trainees. Psychoanalysis, once the dominant theoretical orientation of American psychiatrists, is increasingly a peripheral discipline within psychiatry (and even more within psychology).  In its place – whether as cause or effect – have arisen not only the pragmatic neo-behavioral therapies to which Vitz alludes and the contemporary turn to “spirituality” within psychology but also, as Vitz acknowledges, modern biological interventions.

1.1 The Rise of ‘Biological Psychiatry’

“Biological psychiatry,” the application of neurobiological research and technology and psychiatric genetics within clinical psychiatry, has become in the past 30 years the dominant political and methodological force within American psychiatry, of great consequence not only for psychiatry but for the entire field of “mental health care” and for medicine as a whole. The (re-)ascendancy of biological therapies within psychiatry in the late 20th century is an undisputed and extensively documented clinical and cultural phenomenon, evidenced in part by the dramatic rise in prescription rates of psychiatric medication, both by psychiatrists and by other physicians. Pincus et al. (1998), analyzing data from the National Ambulatory Medical Care Surveys of 1985 and

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1993/1994, documented an increase between 1985 and 1994 of the number of U.S. physician visits during which a psychotropic medication was prescribed (from 32.73 million to 45.64 million) and in the percentage of such visits as a proportion of all physician visits (from 5.1 to 6.5%); much of this was accounted for by a rise of visits in which antidepressants (from 10.99 million in 1998 to 20.43 million in 1993) and stimulants (from 0.57 million to 2.86 million) were prescribed. Olfson and Marcus (2009) document the continuation of this trend into the following decade: between 1996 and 2005, the annual percentage rate of antidepressant medication prescription among persons 6 years of age and older in the United States increased from 5.84% to 10.12%, an increase from 13.3 million to 27.0 million persons treated during that time, although the overall rate of treatment for depression remained the same among these antidepressant-treated patients (26.85% in 1996, 26.25% in 2005) and fewer of them engaged in psychotherapy in addition to taking antidepressant medication (31.5% in 1996, 19.87% in 2005). In 2005, antidepressants surpassed antihypertensive (blood pressure)

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10 Mark Olfson and Steven C. Marcus, “National Patterns in Antidepressant Medication Treatment,” Archives of General Psychiatry 66 (2009): 848-856. For other studies which document this trend toward increased antidepressant utilization, see Randall S. Stafford, Ellen A. MacDonald, and Stan N. Finkelstein, “National Patterns of Medication Treatment for Depression, 1987 to 2001,” Primary Care Companion of the Journal of Clinical Psychiatry 3 (2001): 232-235; Tracy L. Skaer, David A. Sclar, and Linda M. Robison, “Trends in Prescriptions for Antidepressant Pharmacotherapy Among US Children and Adolescents Diagnosed with Depression, 1990 Through 2001: An Assessment of Accordance With Treatment Recommendations from the American Academy of Child and Adolescent Psychiatry,” Clinical Therapeutics 31 (2009): 1478-1487; Mark Olfson et al., “National Trends in the Outpatient Treatment of Depression,” Journal of the American Medical Association 287 (2002): 203-209. The latter study reported in increase in the rate of outpatient treatment for depression from 0.73 per 100 persons in the U.S. in 1987 to 2.33 per 100 persons in 1997, with rates of antidepressant usage among treated individuals increasing from 37.3% in 1987 to 74.5% in 1997 and rates of psychotherapy decreasing from 71.1% in 1987 to 60.2% in 1997. It should be noted that the U.S. Food and Drug Administration’s (FDA’s) issue of a safety advisory in 2003 warning of potential emergent suicidal ideation among adolescents and young adults taking antidepressants has largely halted this exponential growth in rates of depression diagnosis and
medications as the most commonly prescribed class of medications in the United States, with 169.9 million household-reported purchases of antidepressants and 53.0 million prescriptions written during face-to-face physician visits during that year. Of these prescriptions, approximately 30% were written by psychiatrists and the rest by primary care physicians and physicians of other specialties. These prescription trends, most clearly documented for the antidepressants, are seen also with the newer generation of “atypical” antipsychotic drugs, particularly among children.

These prescription trends, most clearly documented for the antidepressants, are seen also with the newer generation of “atypical” antipsychotic drugs, particularly among children.

These documented increases in the prescription (and, presumably, the consumption) of psychiatric medications, particularly antidepressant medication, over the past 20 years are correlated with and complemented by a consistently demonstrable trend toward increased acceptance of psychiatric medication, and its use, among the American population. Analyzing data from the U.S. General Social Survey in 1998 and 2006, for instance, Mojtabai (2009) reported consistent increases over that time in the percentage of Americans who stated that they were very likely or somewhat likely to take doctor-prescribed psychiatric medications “because you were having trouble in your personal life” (29.1% in 2006 vs. 23.3% in 1998), “because you didn’t know how to cope anymore with the stresses of life” (46.5% in 2006, 35.5% in 1998), “because you were feeling


depressed, tired, were having trouble sleeping and concentrating, and felt worthless (49.1% in 2006, 41.2% in 1998), and in the event that “for no apparent reason, you were having periods of intense fear in which you were trembling, sweating, feeling dizzy, and feared losing control or going crazy” (63.7% in 2006, 55.6% in 1998). This follows a study by the same author which documented a gradual increase between 1990 and 2003 in American public willingness to “go for professional help for a serious emotional problem” and comfort level with talking about personal problems with a professional.

The contemporary turn toward biological intervention within psychiatry is, on one level, nothing new: since its evolution as a distinct medical discipline in nineteenth-century Europe and North America, psychiatry has experienced successive waves of biological experimentation and intervention, and neurobiological therapies are at least as prevalent within and constitutive of the history of global psychiatry as the meaning-focused psychotherapies most paradigmatically associated with Freudian and post-Freudian psychoanalysis. Edward Shorter, who is transparent about his pro-biological bias in his narration of the history of psychiatry, writes of a “first [movement of] biological psychiatry” which developed in the nineteenth-century German medical faculties and was focused, through the notable work of neuropathological luminaries such as Wilhelm Griesinger, Theodor Meynert, Carl Wernicke, Franz Nissl, and Aloys

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14 Ramin Mojtabai, “Americans’ Attitudes Toward Psychiatric Medications: 1998-2006,” Psychiatric Services 60 (2009): 1015-1023. There were also corresponding declines in the percentage of patients who stated that they were “very unlikely” or “somewhat unlikely” to take psychiatric medications for each of these indications, though there were still significant proportions (generally 25-50%) of respondents who endorsed this.

Alzheimer, on finding neuroanatomical correlates for mental disorders. This first movement was successful in identifying neurosyphilis as a cause of psychotic symptoms and in identifying neuropathological lesions associated with several specific brain-based disorders (which are now generally considered, for that reason, neurological and/or infectious diseases rather than properly psychiatric ones), but failed to generate any curative therapies or to identify neuroanatomical correlates for schizophrenia, melancholia, or other disorders. For that reason, in Shorter’s narration, it was superseded by the late-nineteenth-century movement within asylum psychiatry, most prominently associated with Emil Kraepelin, which focused on categorizing the various mental disorders through longitudinal symptom-based clinical description rather than neuroanatomical explanation. Although this early biological work continued to exert influence (metaphorically, at least) on the widespread invocation of “nerves” and “nervousness” to account for psychological distress in the first half of the twentieth century (along with related diagnostic terms such as, e.g., “neurasthenia” and “shell shock”), its failure to generate effective therapies contributed to the rise of Freud’s meaning-focused psychoanalysis. Psychoanalytic approaches to psychiatry tended to de-emphasize, if not to disparage outright, the role of somatic/biological interventions in


17 Shorter compares the invocation of “nerves” and “nervous” to the use of the term “stress” as an etiological description for psychological distress in our time; both serve as a cultural-linguistic alternative to insanity or madness. One who is “nervous” (or, in modern speech, “stressed”) is not “mad” (or, we might say, “crazy”), though, one might argue, there are no hard-and-fast boundary markers between these linguistic categories. Shorter writes that in the early twentieth century, “physicians wishing to treat major psychiatric illness among the middle classes, and minor psychiatric illness among any group of the population whatsoever, would have to find settings that fictionalized the nature of the illness” (119). The paradigmatic cure for nervousness was not the dreaded asylum but, rather, the spa.
clinical practice. They became influential both in Europe and North America in the early twentieth century and (due, in part, to the massive transfer of intellectual capital, particularly among Jews, from central Europe to the United States and Britain in the 1930s) dominant in the United States from the 1940s through the early 1970s. But Shorter, who derisively refers to this period as the “psychoanalytic hiatus,” argues conclusively that psychoanalysis should be thought of only as one clinical/intellectual tradition, and perhaps even a minority tradition, within the two-century history of clinical psychiatry.

Contemporary biological psychiatry, which Shorter refers to as the “second biological psychiatry,” did not, of course, arise only within the last three decades of the twentieth century. Its history can be traced to the eager and sometimes desperate efforts of asylum psychiatrists in the early 20th century to find cures for then-incurable forms of madness. The first decades of the twentieth century witnessed a series of creative, and often disturbing, therapeutic experiments on hospitalized asylum patients which yielded some therapies which are still, in updated form, widely utilized (such as electroconvulsive, or “electroshock,” therapy), some which were useful in their time but are now considered dangerous and outmoded (such as insulin coma therapy, when...
patients without diabetes mellitus would be administered insulin until their blood glucose levels became so low that they became comatose), and some which are now regarded as scandalous moral failures on the part of psychiatrists and their institutions (such as lobotomy). In the 1950s, after several decades of experimentation and therapeutic use of various drugs (such as the barbiturates) for sedation and behavioral control among hospitalized psychiatric patients, the first antipsychotic (chlorpromazine, in 1952) and the first antidepressant (imipramine, in 1958) were approved in the United States for clinical use. The widespread use of these drugs among hospitalized inpatients, together with other antidepressants, antipsychotics, and “mood stabilizers” such as lithium which soon followed, raised hopes that patients with chronic mental illness could, with the help of medication, gain sufficient symptom relief so as to allow their adequate function in a non-institutionalized “community” setting. This led to the momentous and hugely controversial phenomenon of “deinstitutionalization” in which, between the 1950s and the 1990s, psychiatric hospitals downsized by approximately 80-90%, transferring the locus of care of those with chronic illnesses such as schizophrenia from the (oft-criticized) institution to the (oft-criticized) “community.”

The “second biological psychiatry,” however, extended far beyond the development of somatic and pharmacological therapies for persons who would otherwise be confined to psychiatric institutions. It also, beginning in the 1950s, extended to

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20 It is clear, of course, that many of these de-institutionalized patients, on discharge, found no “community” to welcome them other than that of the streets; and that many who avoided this fate have done so by securing publicly-financed housing in smaller community-based “institutions” such as group homes, assisted living facilities, and family care homes.
persons with “quotidian anxiety and depression”\(^{21}\) who, though “stressed,” would never require extended hospitalization. “Tranquilizers” such as meprobamate (Miltown) and the benzodiazepines (e.g., diazepam and chlordiazepoxide, marketed as Valium and Librium, respectively) became widely marketed and prescribed for the treatment of minor forms of anxiety and depression, often headlining lists of the most commonly prescribed medications in the United States through the 1980s. Shorter cites a 1973 study showing that in 1970, one out of five American women and one out of thirteen American men were taking one of these “minor tranquilizers and sedatives.”\(^{22}\)

The increasing recognition of undesirable side-effects and addictive potential associated with the benzodiazepines, which led to their regulation as “Schedule IV” controlled substances by the U.S. Food and Drug Administration in 1975, served as a potential contributor to the plateau and gradual decrease in their use and popularity.\(^{23}\) A class of newly-synthesized drugs known as the selective serotonin reuptake inhibitors (SSRIs), however, replaced (and likely contributed to the decline in popularity of) the benzodiazepines as first-line biological treatments for anxiety and depression. Fluoxetine (Prozac), one of the first of these medications approved for clinical use in the United States in 1987, became both a widely-prescribed antidepressant and, thanks to the publication of a flood of popular-press books in the 1990s, the metaphorical face for

\(^{21}\) Shorter, 317.


\(^{23}\) Another factor, surely, was the expiration of their patents, which rendered them free of any pharmaceutical company marketing.
public debates about “cosmetic psychopharmacology.”

Peter Kramer’s *Listening to Prozac*, with its rather giddy and poetic descriptions of the ability of fluoxetine subtly to change the personality of those who take it, spawned a coterie of “Prozac”-themed books and articles which tended either to discourage strongly the use of psychiatric medication in general or, through memoir, further to instantiate its public mystique. Although this public debate quieted considerably in the first decade of the 21st century, why it quieted is a matter for some reflection: data from studies such as that of Mojtabai (2009) above suggest that the active public debate of the 1990s is gradually giving way to a more serene and matter-of-fact acceptance of the use of psychiatric medication for “quotidian anxiety and depression” in the 2000s and 2010s.

It is arguable, then, that the unique characteristic of contemporary “biological psychiatry” is not its biological focus, which is shared to some degree with nineteenth-century psychiatry and, genealogically, with the colorful history of psychosomatic treatments since Galen. It is, rather, its widespread acceptance and use within American culture. Nineteenth-century biological psychiatry produced no lasting therapies to speak of, and its focus was almost entirely on chronically mentally ill individuals quarantined in public and private asylums. Twentieth-century biological psychiatry has produced hundreds of easily marketable therapies, mostly in pill form, and is focused both on community-dwelling persons who never would have been chronically institutionalized

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and on chronically ill persons who, possibly as a result of the availability of these medications, have been reassigned from inpatient wards to various levels of “community” care. It is the scope and widespread acceptance of contemporary biological approaches, more than their biological nature *per se*, which render them novel.

Untangling the various causal webs which account for the rise of contemporary biological psychiatry is a highly debated and complex chicken-and-egg endeavor which is well beyond the scope of the present study. At minimum, such an account would need to consider not only advances in neurobiology, neuroanatomy, pharmacology, genetics, and molecular biology, but also, at least, (a) changing practices of psychiatric diagnosis, some of which will be discussed in detail in future chapters; (b) the role of European and American pharmaceutical companies in sponsoring research, developing drugs, affecting governmental regulation, and marketing both drugs and the diseases which they treat; (c) the role of the U.S. Food and Drug Administration and its European counterparts in regulating psychiatric medication; (d) the role (and the claims) of the various antipsychiatry movements, discussed briefly later in this chapter and in Chapter 2; (e) evolving North American and European attitudes toward medication-taking and medical technology in general; (f) sweeping changes in mental health service delivery models, particularly including the rise of “managed care” in the 1980s and 1990s; (g) the ongoing concerted efforts by influential American psychiatrists to position psychiatry as a firmly “medical” specialty; (h) developments within psychotherapy research and practice; and (i) the complex and often-contented relationship between psychiatrists and “mental health practitioners” of other disciplines such as psychology and social work. It is not my
intent in the present study to disentangle this deeply interpenetrated causal web. My work in the present study does not assume or require any particular account of why biological psychiatry has assumed its present dominant position within American psychiatry. That it has done so is notable enough.

For Christian theological writers and thinkers, the rise of contemporary biological psychiatry is both an occasion for substantial theoretical reflection about embodiment, the passions, reason, and agency and a matter of pressing pastoral concern. A cultural phenomenon of such widespread influence and importance demands a commensurate theological response. It will be the task of this work to provide one such response, first through a close analysis of the contemporary landscape of psychiatric practice and psychiatric nosology, and then through an exploration of the theological anthropology of St. Thomas Aquinas as a helpful conceptual guide. Prior to this, however, it is reasonable to ask: what has been written by Christians about contemporary biological psychiatry?

1.2 Biological Psychiatry in Five Contemporary American Christian Communities of Discourse

American Christian writing about psychiatry and psychology in the late twentieth and early twenty-first centuries reflects every bit of the vibrant and chaotic fragmentation of American Christianity as a whole. As is the case with nearly any issue of public debate, one can find professing Christians advocating nearly any conceivable position one might take regarding the use of modern psychotherapy and/or psychiatric technology. My aim in this introduction is not to survey American Christian attitudes toward psychiatry in a comprehensive way; such an analysis would require empirical methods far
beyond the disciplinary scope of this study and could easily constitute a book-length study in itself. I rather seek briefly to survey the treatment of contemporary biological psychiatry within five overlapping but discernible Christian communities of discourse: the pastoral care tradition, the psychological-theological “integrationist” tradition, the “biblical counseling” tradition, the more recently developed “Christian psychology” movement, and the nascent Catholic-oriented movement centered in the work of the Institute for the Psychological Sciences in Arlington, Virginia.

Some readers of this text will find this list of five discourse-communities too broad, and some may find it too narrow. Several of the discourse-communities which I will touch on here, such as the “biblical counseling” tradition, flourish primarily within self-identified “evangelical” protestant institutions and are attended to very little by large portions of the theological academy. I have chosen to survey these traditions not only because, in my view, they sometimes have interesting and revealing things to say regarding biological psychiatry, but also because they are broadly influential within certain segments of the American Christian population. But even these five communities, despite their considerable diversity, do not collectively represent all contemporary Christian reflection regarding psychiatry; certain theologically-formed (or, at least, theologically haunted) traditions such as Christian Science, Alcoholics Anonymous and, most notably, pentecostalism and faith healing\textsuperscript{26} are represented quite poorly within them. I have chosen these five traditions, rather, because they represent overlapping but nonetheless identifiable communities of academic reflection and clinical practice, self-
denominated through particular academic institutions, particular academic journals, particular modes of clinical training and practice, and/or particular professional societies. I follow here, with some modification, the previous taxonomies of Johnson and Jones (2000) and particularly Johnson (2007), whose careful, charitable, and comprehensive account of these movements I have no intent to recapitulate.

Others may object that as a survey of American Christian treatment of biological psychiatry, the approach here is excessively “top-down,” focusing on academic reflection and publication rather than on the actual observed practices of American clergy and laypeople. There is no doubt, in my view, that such an anthropological and/or ethnographic approach would be necessary for any study which claimed to comprehend American Christian attitudes toward mental illness. I do not make such a claim here. My aim here is, rather, to briefly survey contemporary academic Christian writing about biological psychiatry in order to contextualize the conceptual study which follows in subsequent chapters.

1.2.1 Biological Psychiatry in Pastoral Care and Counseling

The modern pastoral care movement, the oldest and most internally diverse of the five discourse-communities described here, traces its proximate origins to the liberal

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protestant “religion and health” movement of the late 19th and early 20th centuries, including Rev. Elwood Worcester’s “Emmanuel Movement” in Boston in which, between 1905 and 1920, physicians and clergy collaborated in a church-based healing program which applied psychotherapeutic insights from the still-forming field of scientific psychology. The movement gained more enduring form, however, in the work of Anton Boisen, who emerged from at least two extended psychiatric hospitalizations for psychotic thinking and behavior to found in 1925 the clinical pastoral education (CPE) movement, in which seminarians gained immersive experience in counseling and pastoral presence not though the study of theological texts but through the study of “living human documents” in health care, and often psychiatric, settings. This emerging (almost exclusively protestant) pastoral care movement, structured by institutions such as the Council for Clinical Training and the Federal Council of Churches, was further nurtured by (and generally open to) developing trends within modern psychology, particularly by the work of the seminarian-turned-psychologist Carl Rogers and the minister-turned-humanistic-psychologist Rollo May. By mid-century,

[33] May’s first book, *The Art of Counseling*, was published while he was still working as a minister and was developed “from lectures originally given at the seminars of student workers on ‘Counseling and
the pastoral care movement had come into its own through the work of Seward Hiltner, Helen Flanders Dunbar, Russell Dicks, Carroll Wise, and later Howard Clinebell, Thomas Oden, and Wayne Oates.\textsuperscript{34} Presently, the pastoral care movement survives in the ongoing clinical pastoral education movement, still a widely-practiced component of protestant theological education; in the professionalized disciplines of hospital chaplaincy and pastoral counseling, together with professional organizations such as the Association of Professional Chaplains and the American Association of Pastoral Counselors; in academic organizations such as the Society for Pastoral Theology; and in academic journals such as the \textit{Journal of Pastoral Care and Counseling}, \textit{Pastoral Psychology}, the \textit{Journal of Religion and Health}, and the \textit{Journal of Pastoral Theology}.

The pastoral care movement is theologically and theoretically a large tent, lacking any centralized authority or narrative. It has given expression, in practical/psychological form, to nearly every theological trend within the modern American liberal/“mainline” protestant theological academy, from Barth to Tillich to Hartshorne to black, feminist/womanist, liberation and queer theology. It also has displayed the influence, at various times, of psychological thinkers as diverse as Rogers, William James, Freud,\textsuperscript{35} Jung,\textsuperscript{36} Rollo May, and Aaron Beck.\textsuperscript{37} It is therefore impossible to name a unitary

\begin{footnotesize}
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\item \textsuperscript{34} For accounts of this history see Alison Stokes, \textit{Ministry After Freud} (Boston, Mass.: Pilgrim Press, 1986); Holifield, \textit{History of Pastoral Care in America}, 210-306; Charles V. Gerkin, \textit{An Introduction to Pastoral Care} (Nashville: Abingdon, 1997), 21-78.
\item \textsuperscript{35} e.g., Donald Capps, \textit{The Depleted Self: Sin in a Narcissistic Age} (Minneapolis, Minn.: Fortress Press, 1993).
\item \textsuperscript{36} e.g., Deborah van Deusen Hunsinger, \textit{Theology and Pastoral Counseling: A New Interdisciplinary Approach} (Grand Rapids, Mich.: Wm. B. Eerdmans, 1995).
\item \textsuperscript{37} e.g., Susan J. Dunlap, \textit{Counseling Depressed Women} (Louisville, Ky.: Westminster John Knox Press, 1997).
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conception on the part of writers in pastoral care to biological psychiatry. A survey of pastoral care texts since the 1950’s, however, demonstrates several consistent themes across time.

The pastoral care movement has often been criticized both internally\textsuperscript{38} and externally\textsuperscript{39} by those who charge that it has historically demonstrated an uncritical acceptance of the modern psychologies. Whether or not this criticism is historically justified – it is certainly the case that seminal pastoral care thinkers like Boisen and Paul Pruyser\textsuperscript{40} went to considerable lengths to differentiate pastoral counseling from psychiatry and psychology – it cannot be said of the approach of pastoral care to biological psychiatry. Boisen, certainly, was quite turned off to the (pre-pharmacologic) biological approaches with which he was treated as a psychiatric inpatient; it is plausible to understand the CPE movement as an outgrowth’s of Boisen’s disgust with psychiatric approaches which bracketed or ignored the meaning of the thought content of psychiatric inpatients.\textsuperscript{41} On the whole, however, the mid-century pastoral theologians had little to say, either approving or critical, about biological psychiatry. Although the pastoral care journals of the time (e.g., \textit{Pastoral Psychology}) featured many articles (much more

\textsuperscript{38} see Holifield, 335.
\textsuperscript{39} Jay E. Adams, \textit{Competent to Counsel} (Grand Rapids: Baker, 1970), xi-xii.
\textsuperscript{40} Paul Pruyser, \textit{Minister as Diagnostician} (Louisville, Ky.: Westminster John Knox Press, 1976).
\textsuperscript{41} Quoting approvingly, in his autobiography, a letter which he had written years earlier while an inpatient, Boisen writes, “The fundamental difficulty seems to me this: A man whose fundamental derangement is not of the body but in his philosophy of life is sent to a place where they look only at the physical side. Most of the doctors, I think, are not religious men. . .” Later, quoting a letter to his mother, he writes that “in many of its forms, insanity, as I see it, is a religious rather than a medical problem, and any treatment which fails to recognize that fact can hardly be effective. But as yet the church has given little attention to this problem.” Boisen, \textit{Out of the Depths}, 101, 111.
commonly than is the case now) with “psychiatry” in the title,\textsuperscript{42} the “psychiatry” envisioned was nearly always psychoanalysis. Here, the early pastoral theologians generally sought less a transformation of Christian pastoral care by psychoanalysis as much as a partnership of pastor/theologians with psychodynamic psychiatrists who (breaking from psychoanalytic orthodoxy) were congenial toward religion. This approach is stated quintessentially by William C. Menninger, a noted psychiatrist of the time, in the first issue of Pastoral Psychology:

\begin{quote}
There is need for the co-operation of clergymen and psychiatrists. Pastors should learn to recognize when the persons who come to them for help are mentally ill and need psychiatric consultation. Psychiatrists should recognize the powerful emotional support that many individuals derive from their religious faith. In some emotional crises, a religious mentor may be able to provide more important support than can the psychiatrist. There need be no conflict as to when each can serve best in the resolution of problems. The pastor and priest deal entirely with conscious material. The psychiatrist begins with conscious material but, in addition, sets out to find the unconscious sources of inner conflict . . . Despite a few irrationally prejudiced remarks and articles written by those who would stir up antipathies, psychiatrists and clergy are working together, and understanding and borrowing support from each other. The pastor should be able to render psychiatric “first aid.” Cross referral (more rare for the psychiatrist to refer to the pastor) is desirable.\textsuperscript{43}
\end{quote}

This split-domain model is typical of the mid-century pastoral care: ministers/clergy, appreciative of and informed by psychoanalytic psychiatry, would attend to the spiritual needs of psychiatric patients, while psychiatrists, appreciative (\textit{pace} Freud) of the

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constructive and healthy role of religion, would attend to unconscious conflicts.\textsuperscript{44} This writing, however, rarely focused on biological approaches in psychiatric treatment. Where biological psychiatry is discussed directly,\textsuperscript{45} it is portrayed as an insufficient, though perhaps necessary, form of care. But biological psychiatry was never the central focus of the pastoral care thinkers even when psychiatry as a field dominated the pastoral theologians’ agenda.

In the past half-century, the pastoral care movement has recognized and accommodated the rise of biological psychiatry, but with little critical engagement; one looks in vain for a large pastoral-theological literature regarding either psychiatric technology or biological psychiatry. This is, in part, because psychiatry as a field has become much less central to the pastoral care agenda. As clinical psychiatry became less and less focused on psychotherapy, the clinical pastoral counseling literature (i.e., as found in the \textit{Journal of Pastoral Care and Counseling}) became less and less focused on psychiatry, turning attention increasingly to clinical psychology. Pastoral theologians, as well, grew more and more attentive to issues of gender, race, and class; this further diverted the attention of the field from biological psychiatry.\textsuperscript{46} Clinical pastoral care

\textsuperscript{44} See, e.g., Granger E. Westberg, \textit{Minister and Doctor Meet} (New York: Harper and Brothers, 1961), 123-136; Wayne Oates, \textit{The Christian Pastor} (Philadelphia: Westminster Press, 1951), 88-92, 140-150; Wayne Oates, \textit{Religious Factors in Mental Illness} (New York: Association Press, 1955). For a serious effort to provide helpful theological education to clinicians desiring to be attentive to religious concerns, see Wayne E. Oates, \textit{The Religious Care of the Psychiatric Patient} (Philadelphia: Westminster Press, 1978). Oates, in this later work, acknowledges the force of biological psychiatric research (pp. 121-122) and advises pastors to refer patients to psychiatrists for possible hospitalization and/or medication treatment if doing so would more quickly alleviate the suffering of major depression (123). He assumes the validity of the distinction, widely held in his time but (controversially) less favored in the present, between “reactive” and “endogenous” depression, with medication reserved for the latter.\textsuperscript{45} Oates, \textit{Religious Factors in Mental Illness}, 182-185.\textsuperscript{46} Rodney J. Hunter, “Pastoral Theology: Historical Perspectives and Future Agendas,” \textit{Journal of Pastoral Theology}, 16 (2006): 7-30. In a revealing line, Hunter states: “What psychopathology was to our
writers such as Howard Clinebell, who was influenced by the interpersonal theory of Harry Stack Sullivan as well as by these new movements, grew more attentive to the social context of pastoral care and less focused on psychopathology per se; Clinebell’s widely read *Basic Types of Pastoral Care and Counseling* says little about psychiatric technology or severe mental illness, other than encouraging pastors and pastoral counselors to refer such patients to a physician.\(^{47}\) John Patton’s widely cited text *Pastoral Care in Context*, giving voice to this changed focus in the field, encourages pastoral caregivers to move beyond (without fully rejecting) both the “classical paradigm” (Christian pastoral care before “the advent of modern dynamic psychology’s impact on ministry”) and the “clinical pastoral paradigm” (psychologically-informed care focused on individuals in a dyadic relationship with a caregiver) in favor of the “communal contextual” paradigm in which “pastoral care is understood to be a ministry of a faith community which reminds members of God’s scattered people that they are remembered.”\(^{48}\) Nancy Ramsay continues this theme by writing, in a 2004 state-of-the-field essay, of pastoral care’s transformation by the “Communal Contextual” and the “Intercultural” paradigms (the latter focusing on issues of pluralism) as successors to the clinical forbears – the focus of its healing concern – violence, oppression, and victimization are to us today. What psychotherapy had meant as praxis of liberation to a previous generation has broadened to include prophetic social critique and transformation as major, and sometimes principal pastoral theological agendas in our own” (13).


clinical pastoral paradigm. Ramsay’s often-cited 1998 text *Pastoral Diagnosis*, reflecting the field, eschews the “medical/psychiatric” model of diagnosis in favor of a hermeneutical, communally-focused, contextual diagnostic model. Revealingly, however, her account of the “medical/psychiatric” model presumes the (long-eroded) theoretical dominance of psychoanalysis and psychodynamic psychiatry; it does not engage either biological psychiatry or the diagnostic traditions which undergird most modern psychiatric practice. Carrie Doehring, even more recently, writes of the transformation of pastoral care from a “modern” (rational, individualistic, medical, knowledge-oriented) to a “postmodern” (narrative, communal, contextual) frame.

I do not intend here to provide a global evaluation or critique of this “communal/contextual” turn in pastoral care. My suggestion, rather, is that this move, however defensible and needed, has diverted much of the focus of the pastoral theologians away from medicine and psychiatry (and therefore away from biological psychiatry) toward other concerns. We must not overgeneralize, though: there is still a substantial volume of books and journal articles, generally associated more with the “pastoral counseling” than with the “pastoral theology” wing of the pastoral care movement, which deal directly with the care of persons with mental illness. If

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49 Nancy J. Ramsay, “A Time of Ferment and Redefinition,” in *Dictionary of Pastoral Care and Counseling*. Expanded edition, ed. Rodney J. Hunter (Nashville: Abingdon, 2005), 1349-1369. Ramsay points out that even the term “pastoral care” is being gradually replaced by less tradition-specific terms, e.g. “spiritual care” or “soul care.”

50 Nancy J. Ramsay, *Pastoral Diagnosis: A Resource for Ministries of Care and Counseling* (Minneapolis: Fortress Press, 1998). I should state that I find Ramsay’s arguments regarding the hermeneutical and teleological nature of diagnosis fundamentally sound and will be using this as a resource in later chapters.

psychiatric medications and other somatic technologies are dealt with at all in these books and articles, some version of the split-domain model articulated by Menninger is almost always proposed.\textsuperscript{52}

Despite these dominant tendencies of the contemporary pastoral care movement either to disinterest in or to a split-domain acceptance of biological psychiatry, there are nonetheless examples within the pastoral care movement of direct conceptual engagement with biological psychiatry. First, feminist psychological thinkers have raised concerns that biological psychiatry renders women vulnerable to the demeaning effects of medicalization, blinding both women and the “experts” who treat them to the political nature of the diagnostic and treatment endeavor.\textsuperscript{53} Second, others have argued that the split-domain model of care, in which pastoral counselors focus on the spiritual and physicians focus on the biological, leads to a gnostic view of the person which subverts


\textsuperscript{53} Susan J. Dunlap, \textit{Counseling Depressed Women}, 96-97. Dunlap, it should be said, alludes to these arguments but does not advocate them directly.
both the non-Cartesian language of scripture and the body-affirming logic of the incarnation. Reed (1981), arguing that the use of psychiatric medications is sometimes appropriate, worries about the “tacit scientific reductionism” of biological psychiatry and argues that both psychiatrists and pastoral counselors have a stake in the relationship of body to mind:

Reed then argues that the “religious specialist” must inhabit a diagnostic role, “to assess the meaning of the body-words, to distinguish true from false. . .”; a priestly role of entering “into the phenomenal world of the mentally ill person, . . . immersing oneself into the broken body-word of the mentally anguished;” a prophetic role to stand against reductive explanations, such as by “[explaining] how it is that schizophrenic grandiosity must also be understood as pride,” an an interpretive role to “continue to treat those body-words as charged with meaning, as symbols and not mere signs of synaptic disruption.”

Others who have set forth similar concerns include Ashbrook (1995), who argues against any separation of medication from meaning, “soul” from “soma,” while

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55 Ibid., 9-10.
maintaining that medication is sometimes necessary;\textsuperscript{56} Bringle (1996), who worries about the reductive tendencies of the medical model of depression but then defends the prudential use of medication when doing so, “far from offering an escape from [life’s] demands, [would] facilitate a fuller engagement with them;”\textsuperscript{57} and Martignetti, who argues that “in many, and perhaps most circumstances, medication should be a final resort for the pastoral therapist.”\textsuperscript{58} But it must be said that these conceptual engagements with biological psychiatry, though sporadically present, are generally rare in the contemporary pastoral care literature.

1.2.2 \textit{Biological Psychiatry in Psychological-Theological Integrationism}

The psychological-theological “integrationist” movement, along with its evangelical step-sibling biblical counseling, has dominated American evangelical protestant discussions of psychology and psychiatry for the last half-century. Integrationism, like biblical counseling, remains nearly invisible in the writing of the modern pastoral care tradition.\textsuperscript{59} It has been no less influential within the broad tradition of American evangelicalism, however, than the pastoral care tradition has been within modern American liberal protestantism. Furthermore, the gradual eclipse of the normativity of “mainline” protestantism within American culture, together with the


\textsuperscript{59} Rodney J. Hunter, “Pastoral Theology,” 20-22. There are notable exceptions to this trend, particularly in the careful and generous work of Don Browning; see Don Browning and Terry Cooper, \textit{Religious Thought and the Modern Psychologies}. 2nd ed. (Minneapolis, Minn.; Fortress Press, 2004), 245-268.
increased cultural and political visibility of American evangelicals in the past 40 years, has bolstered the cultural significance of these evangelical movements such that no serious student of contemporary American Christian engagement with psychology and psychiatry, however theologically inclined, can afford to ignore them. The modern pastoral care movement has never produced a figure of such cultural importance, for better or for worse, as James Dobson.

Integrationism emerged, in most standard accounts, during the 1950s in the context of two distinguishable traditions: the neo-evangelical movement of Carl F. H. Henry and E. J. Carnell, whose advocacy of a less defensive and more culturally engaged version of early-twentieth-century fundamentalism led to the foundation of institutions such as Fuller Theological Seminary (1947) and the periodical Christianity Today (1956); and the Dutch Reformed tradition which, less battered (though not untouched) by the early-twentieth-century fundamentalist-modernist controversies and always informed by a Kuyperian vision of Christian cultural engagement and a vision of the “book of nature” as a locus of revelation. Despite the significant sociological and theological differences in these two traditions (i.e., between Dutch Reformed confessionalism and neo-evangelical revivalism), the integration movement gradually integrated itself from the 1950s through the 1970s, assuming the institutional and organizational forms which continue to sustain it. More than any of the other movements treated here, the

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The integration movement has taken defined forms both on an academic and a popular level. Academically, the movement is sustained by the academically-focused Christian Association for Psychological Studies (CAPS), several accredited graduate training programs in clinical psychology (most notably the School of Psychology of Fuller Theological Seminary, Rosemead School of Psychology of Biola University, and Wheaton College Graduate School), and two academic journals dedicated to integration issues (The Journal of Psychology and Theology, published by Rosemead, and the Journal of Psychology and Christianity, published by CAPS). On a popular level, the movement has spawned several well-known evangelical-protestant mental health hospitals and clinics (e.g., the Dutch Reformed Pine Rest Christian Hospital and the neo-evangelical Minirth-Meier and Rapha organizations) and a host of psychologists-and-psychiatrists-turned-popular-authors (e.g., Larry Crabb, Gary Smalley, Frank Minirth, Gary Chapman and James Dobson) who, fueled by evangelical publishing houses and lingering suspicion of modern psychology on the part of many American protestant evangelicals, have produced and sold millions of books and lectures aimed at non-professional readers. Integrationism is also reflected heavily in the evangelical “Christian counseling” movement reflected organizationally in the ~50,000-member American Association of Christian Counselors.

This history has distinguished integrationism from the modern pastoral care movement in several ironic ways. Ironically, given the oft-levied criticism that the

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modern pastoral care movement has uncritically accepted the modern psychologies, the integration movement has, in relation to the pastoral care movement, historically been much more the province of professionally trained psychologists (with the occasional influence of psychiatrists) than of professionally-trained theologians. Although it is important to avoid simplistic categorical generalizations – since this history is filled with counterexamples and, as we will soon see, highly contested – it is nonetheless the case that the early histories of both the modern pastoral care movement and the integration movement were each characterized by a “distant-shore” mentality, with the pastoral theologians looking to the modern psychologies to critique and to transform practical theology and the integrationist psychologists looking to theology to critique and to inform contemporary psychology. (Neither, early on, showed much interest in Christian history.) But whatever the success of this “integration” movement, it is important to note that the integration movement has been, and continues to be, more linked to contemporary psychology than either its biblical counseling alter ego or the modern pastoral care movement. The accredited integrationist clinical and counseling psychology (Ph.D. and Psy.D.) graduate programs, for example, unlike any training programs in pastoral theology, train professional psychologists and are fully subject to the accreditation standards of the American Psychological Association. Also – again, ironically in historical context – the integration literature is filled with articles

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63 Thomas C. Oden, Care of Souls in the Classic Tradition (Minneapolis, Minn.: Fortress Press, 1984).
encouraging the production of more “scientific” empirical work, and the integrationist journals, unlike their pastoral care counterparts, increasingly publish reports of empirical research.

Despite – and perhaps, I will soon argue, in part because of – the ongoing close relationship between integrationism and American psychology, one finds in the integrationist literature surprisingly little conceptual engagement with biological psychiatry. Furthermore, when psychiatric medication and other psychiatric somatic technologies (e.g., ECT) are discussed in the academic integration literature, they are treated in a manner remarkably similar to that of modern pastoral care: cautious acceptance, deference to physicians, agreement about some version of the split-domain model. Gary Collins, a psychologist whose manual Christian Counseling has served for nearly three decades as an integrationist textbook for aspiring Christian counselors (most of whom are not themselves psychologists), devotes only a few paragraphs in his 964-page 3rd edition to biological psychiatry, and these are both pragmatic and deferential to the medical model of mental disorder. For serious mental disorders such as schizophrenia, medications can cause problematic side-effects but “despite these dangers, it doubtless is true that to treat serious mental disorders without psychopharmacological intervention is ‘simply irresponsible.’” For counselees who are depressed, medication may be indicated if the depression has a “physical basis” or “if the depression does not yield to . . . initial counseling,” though drugs may provide only symptom relief without

removing the underlying cause of the depression. The same general principles apply to the use of tranquilizers for anxiety disorders. Yarhouse, Butman, and McRay, in the most comprehensive integrationist text on psychopathology published to date, offer much the same advice for the treatment of depression, anxiety, and schizophrenia, though they include brief discussion of the “biological foundations of mental illness” in which they describe the development of psychotropic medication as a gift of God, argue for the “essential unity of mind and body,” and express concern about the “tendency toward biological reductionism,” the “medicalization of nearly all mental and emotional disorders,” and the “sense of diminished responsibility” which derives from a “nothing-but” view of psychiatric medication. Although the integrationist journals have commonly published papers arguing for a non-dualistic account of the person (such as Nancey Murphy’s “nonreductive physicalism,” which we will explore further in later chapters), these contributions rarely engage biological therapeutic interventions in much detail. Papers in the integrationist journals focusing on individual mental disorders

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66 Ibid., 130-131. For a similar view by a psychiatrist associated with the integration movement, see Frank Minirth, Christian Psychiatry (Old Tappan, N.J.: Fleming H. Revell, 1977), 167-175.
67 Ibid., 153.
generally assume the normativity of treatment with medications, while emphasizing that medications will often not cure the underlying cause of a disorder.\textsuperscript{70}

As with the pastoral counseling movement, there are scattered examples of direct engagement by integrationist-leaning thinkers with biological psychiatry, though they are not particularly common. Both \textit{Christianity Today} and the \textit{Christian Century} published articles responding to Kramer’s \textit{Listening to Prozac} by integrationist thinkers, each of which raised questions (without definitively proposed answers) about whether the widespread use of antidepressants like fluoxetine (Prozac) among depressed and anxious Christians blunted psychic pain without leading to changed life patterns.\textsuperscript{71} Each of these articles embraces the medical model of major depression and, despite raising questions, endorses the use of antidepressants in at least many cases. Barshinger’s \textit{Christianity Today} article, for example, quotes one evangelical scholar who holds that “it is no more shameful or weak to accept psychoactive medication to return to mental health than it is to do so for physical problems such as ulcers” and another who describes Prozac as a divine gift comparable to God’s knocking Saul off of his horse and the angel Gabriel appearing to the Virgin Mary.\textsuperscript{72}


\textsuperscript{72} Barshinger et al., 36-37.
Boivin (2003) provides a more recent strident integrationist endorsement of the use of antidepressant medications. Accepting both the medical model of depression (160) and the broad utility of psychiatric medication in the treatment of mental disorders (162-163), he critiques any “religious view” that “tends to see the physical realm as a corrupted or imperfect representation of a metaphysical reality of greater and more enduring value,” that “places a strong emphasis on repeated, dramatic, and capricious intervention by God in the human condition in a manner that supercedes and overshadows the natural order,” that “[emphasizes] a need for its adherents to choose between a metaphysical order and a natural one,” and/or which “[views] itself as a bulwark of Christian values against a hostile culture” (165-166). This view, equated with “Augustinian Platonic dualism,” is no longer adequate in the new world of neuroscience: “trying to accommodate the implications from the present behavioral neuroscience revolution into the old wineskins of Augustinian Platonic dualism will likely burst them” (167). Boivin proposes instead a “Hebraic model of the person” characterized by a unitary conception of body and soul, a social and physical environment which exerts “deterministic influence,” and a de-emphasis on freedom of the will. “Pharmaceutical healing (or any scientifically based protocol) of emotions” in such a model “can be framed within the context of a theologically based understanding of who and what that person was meant to be as a valued part of God’s creation and order” (172). Specifically, psychiatric medication can be redemptive: “our limited pharmaceutical attempts to heal broken brains here and now are but a dim and feeble hint as to the full restoration of all

that we were meant to be as physical being in a restored physical order” (175). In a later response\textsuperscript{74} to a set of questions\textsuperscript{75} directed to him as a result of this article, Boivin is less guarded about the salvific possibility of technology:

\textit{The first step in freedom is to realize how determined we are.} It is in understanding those deterministic processes and engineering effective technologies in response to them that we can achieve our therapeutic goals and not by denying the lawfulness of such processes. It is in understanding and effectively exploiting the naturalistic processes within which we as humans are immersed that we can intentionally move towards wholeness. Thus, we achieve autonomy only in the sense that we responsibly orchestrate those processes that will shape us as a people in a redemptive and constructive manner as inspired by a Christian ideal and worldview.\textsuperscript{76}

If, as some integrationists fear, antidepressants efface psychic pain which might otherwise motivate behavioral change, so much the better:

Although suffering can have a redemptive purpose, I strongly feel that to whatever extent it is within our capability, our first obligation in medicine and psychology is to alleviate pain and suffering, wherever and whenever we encounter it and through whatever means we can (including and especially through systemic means in the political, economic, and ecological realms).\textsuperscript{77}

I have chosen to highlight Boivin’s article in some length not because his views can be generalized to the integration movement as a whole (he speaks, as most authors do, only for himself), but because he is one of the only integrationists to have devoted recent sustained theological consideration to psychiatric medication and because he is admirably clear about the relation of his technological optimism with a particular physicalist understanding of the human person (a view which clashes very illuminatively with the Thomistic view I will advance in the second half of this work). Indeed, if any


\textsuperscript{76} Boivin, “Response to Kathleen H. Storm,” 18-19.

\textsuperscript{77} Ibid., 19.
generalization regarding an integrationist understanding of psychiatric technology is possible, it is that integrationists have not yet engaged, as a movement, in the sustained work necessary to develop an understanding of psychiatric technology commensurate to their detailed critical work on the psychotherapies.\textsuperscript{78}

Why might this be the case? As with speculation regarding the rise of biological psychiatry, the causes are likely multiple and hypothesis-testing regarding cause is difficult. I suggest, however, one factor to consider, namely the possibility that the close association of the integration movement with modern psychology (particularly in its academic training programs) has diverted its attention from matters more traditionally associated with psychiatry. Despite the obvious links between psychology and psychiatry, they are in many ways different fields with different histories, different training models, different (although contested) practice boundaries, different fora for publication, and different academic and professional societies. Whereas historically the psychotherapies have been heavily influenced both by psychology and psychiatry, somatic and biological interventions, which evolved from treatments directed to psychiatric inpatients, have historically fallen within the domain of psychiatry. It would not be surprising, then, if the psychological focus of the integrationist movement hindered a sustained focus on the theological issues inherent in biological psychiatry.

\textsuperscript{78} e.g., Stanton L. Jones and Richard Butman, \textit{Modern Psychotherapies: A Comprehensive Christian Appraisal} (Downers Grove, Ill.: Intervarsity Press, 1991).
1.2.3 Biological Psychiatry in ‘Biblical Counseling.’

The ‘biblical counseling’ movement, traditionally associated with harsh critiques of psychiatry and psychology, is often understood in radical opposition to evangelical integrationism. In fact, it is its estranged Reformed sibling, embodying not the Kuyperian complementary “nature and scripture” epistemology of the Dutch Reformed founders of the Christian Association for Psychological Studies but, rather, the staunch bibliocentrism and presuppositionalism of neo-Princetonian American Presbyterianism as it emerged from the bloody fundamentalist-modernist controversies earlier in the century. Biblical counseling is a resourceful movement which, though nearly invisible in the writings of the modern pastoral care movement and within theological schools associated primarily with the “mainline” protestant churches, is extraordinarily influential within certain streams of American evangelicalism and for that reason alone deserves careful consideration in any overview of American Christian responses to biological psychiatry. It also deserves consideration because of its ideological and theological contrasts with the two movements described so far, although it is important to note from the outset that many of the most influential leaders in the movement have adopted a much more nuanced and less polemical stance toward modern psychiatry and psychology than was the case.

79 The Southern Baptist Theological Seminary in Louisville, Kentucky, for example, explicitly reformed its pastoral counseling curriculum and faculty in 2005 to move from the “pastoral counseling” model pioneered by Wayne Oates (who was affiliated with the seminary before teaching at the University of Louisville School of Medicine) in favor of a “biblical counseling” model. For a news release praising this move, see Jeff Robinson, “Southern Seminary Launches New Vision for Biblical Counseling,” Baptist Press (Feb 15, 2005), available at: http://www.bpnews.net/bpnews.asp?ID=20152. Accessed March 17, 2011. For a story with a more critical view, see David Winfrey, “Southern Seminary Nixes Pioneering Curriculum for ‘Biblical Counseling,’” Associated Baptist Press (Feb 22, 2005), available at: http://www.abpnews.com/content/view/199/118/. Accessed March 17, 2011. Many of the other Southern Baptist seminaries, which collectively graduate thousands of future pastors, ministers, lay leaders, and missionaries each year, have adopted a similar curriculum.
during the movement’s early history. We must be careful, therefore, not to overstate – and therefore to oversimplify – the contrasts.

Biblical counseling, however latent as a permanent possibility within American protestant Christianity, traces its origin as a movement to the ideological and political leadership of Jay Adams, a conservative Presbyterian pastor and teacher whose *Competent to Counsel* (1970) is widely regarded as a founding text of the movement. Adams institutionalized the new movement, which he referred as “nouthetic counseling” (from Gk. *noutheteo*, “to admonish,” e.g. Col 3:16), by founding the Christian Counseling and Educational Foundation (CCEF) in suburban Philadelphia while a professor of practical theology at Philadelphia’s conservative-reformed Westminster Theological Seminary. In subsequent years, the growing movement experienced considerable ideological tensions and shifts, the details of which are beyond the scope of this brief review. Currently the movement can be identified with two main streams, both of which trace their source in Adams’ thought: the more avowedly psychology-rejecting wing associated with the National Association of Nouthetic Counselors (NANC; www.nanc.org) and Adams’ own Institute for Nouthetic Studies (www.nouthetic.org), on one hand, and the more accommodationist wing associated with the present-day CCEF (www.ccef.org) under the leadership of David Powlison and Edward Welch. The *Journal of Biblical Counseling*, published by the CCEF, serves both as a forum for

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80 Jay E. Adams, *Competent to Counsel*.
81 Other more virulently antipsychiatric voices loosely associated with the movement are Richard Ganz (*PsychoBabble: The Failure of Modern Psychology -- and the Biblical Alternative* [Wheaton, Ill.: Crossway Books, 1993]) and, particularly the “Psychoheresy Awareness Ministries” (http://www.psychoheresy-aware.org), which is primarily targeted at integrationism but which regards even the mainstream biblical counseling voices as essentially integrationist in nature.
discussion within the movement and as a mouthpiece for the leaders of the CCEF. This relative centralization makes a “top-down” account of biblical counseling somewhat more straightforward than is the case with either of the two movements already discussed.

The 1970 introduction of Adams’ *Competent to Counsel* provides the basic ideological framework for the subsequent movement. In this autobiographical account, Adams describes his own disillusionment, as a young conservative reformed pastor, with the Rogerian and psychoanalytic orientation of the mid-century pastoral care literature. He writes that he “gradually . . . drifted into hit-or-miss patterns of counseling growing out of on-the-spot applications of biblical exhortations as I remembered them.” Adams’ work was transformed further through a Lilly Foundation-funded summer apprenticeship with the American behavioral psychologist O. Hobart Mowrer (1907-1982), who in his later career (influenced by Harry Stack Sullivan) pioneered the use of therapeutic “integrity groups” founded on “honesty, responsibility, and involvement with mutual concern and trust.” Taken with Mowrer’s emphasis on responsibility, Adams writes that he emerged with the conviction that many hospitalized psychiatric patients were institutionalized “because of their own failure to meet life’s problems” – that is, “because of their unforgiven and unaltered sinful behavior” – and that the Bible alone provided sufficient resources for counseling. Fueled by contemporary antipsychiatric critiques

82 Ibid., xiii.
83 Ibid.
85 Adams, *Competent to Counsel*, xvi.
such as those of Thomas Szasz and Ronald Leifer, as well as by the reformed
“presuppositionalism” of his teacher and Westminster colleague Cornelius Van Til.\textsuperscript{86}
Adams then turned full-scale against the “medical model” of contemporary psychiatry,
which (in Adams’ view) tended to locate the source of psychopathology outside the
moral agency of the person, in favor of a Christian reconstruction of Mowrer’s “moral
model” in which “problems may be solved, not by ventilation of feelings, but by
confession of sin.”\textsuperscript{87}

In this brief account we can trace nearly all the common threads of the biblical
counseling movement. First, we find an emphasis on personal responsibility and,
correlatively, an emphasis on personal sin as the besetting problem of humans. Second,
we find a strong \textit{sola scriptura} view of the Bible as both necessary and sufficient for
understanding the human predicament and the means of creditable pastoral counseling.
Third, we find marked distrust of modern psychology and psychiatry – which Adams
lumps together under the “medical model” of psychopathology – on the ground that they
arise from non-Christian presuppositions and therefore cannot either truthfully interpret
the human condition or aid faithful Christian pastoral care. Fourth, and correlatively, we
find the view that the \textit{pastor} and the \textit{church congregation}, not the
psychologist/psychiatrist/therapist and the clinic, are the appropriate loci of Christian
counseling (Adams: “A good seminary education rather than medical school, or a degree
in clinical psychology, is the most fitting background for a counselor”\textsuperscript{88}). Fifth, we find

\textsuperscript{86} Ibid., xxi n1.
\textsuperscript{87} Ibid., xvii.
\textsuperscript{88} Ibid., 61.
the seeds of a counseling method which is both directive and (at times) confrontational, focused on admonition and the impartation of (a certain practical interpretation of) biblical truth.

In his critique of the “medical model” of mental illness, however, it is important to note that Adams does not reject medicine per se. Following the logic of Thomas Szasz, who in The Myth of Mental Illness and later writings embraced a realist, non-constructivist account of physical disease (in Szasz’ words, “physicochemical disorder”) and then criticized psychiatrists for metaphorically importing this medical model into their own work with “problems of living,” Adams distinguishes between psychological symptoms which are caused by underlying medical conditions, and which are therefore the rightful province of the physician, from psychological symptoms which are fundamentally behavioral and spiritual in nature, and which are therefore the rightful province of the pastor. The pastor, for Adams, “works back-to-back with the physician.”

This Szaszian stance, as appropriated by Adams and the biblical counseling movement, has had a mixed legacy regarding biological psychiatry. On the one hand, Adams – and, in attenuated form, his various successors – are very reluctant to concede any sphere of influence to psychiatrists regarding “problems of living;” these are properly, for Adams, the domain of the Christian pastor. Following many antipsychiatry (and some psychoanalytic) thinkers of his time, Adams posited that even many with

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90 Adams, Competent to Counsel, 37.
diagnoses such as schizophrenia were in fact “people with unsolved personal problems.” But, on the other hand, if an “organic” cause of particular symptoms could be proven, then treatment of this organic cause would be the domain of the physician. Although Adams has in mind primarily “organic malfunctions affecting the brain that are caused by brain damage, tumors, gene inheritance, glandular or chemical disorders,” he explicitly states, while considering a now-discredited biological theory of his time regarding the etiology of schizophrenia, that if an organic cause of schizophrenia could be found, it would fall to the physician to treat this “chemically based” disorder.

I have treated Adams at some length in order to show that biblical counseling, the most avowedly anti-psychological of the movements discussed in this chapter, in fact contains within its Adamsian soil both the seeds of robust engagement with medicine and neurobiology (since the biblical counselor must always think about whether a counselee’s problem is organically based and therefore the province of a physician) and the seeds of possible embrace of biological psychiatry if new research were to uncover “organic” roots for particular mental disorders. It would not be surprising, therefore, if the subsequent movement were to demonstrate both attention to and ambivalence about emerging trends in biological psychiatry.

91 Ibid., 29.
92 Ibid., 28.
93 Ibid., 39. Even in this early work, Adams’ sympathetic engagement with neurobiological work stands in marked contrast to his categorical rejection of psychoanalytic psychiatry. It is clear, then, that the Szaszian “anti-psychiatry” tradition which Adams here appropriates is in fact more “anti-psychoanalysis” than “anti-psychiatry.” Any disorder for which a “chemical basis” can be established is, on this logic, exempt from the Szaszian critique. See also Jay Adams, “The Big Umbrella,” in Adams, The Big Umbrella and Other Essays and Addresses on Christian Counseling (Grand Rapids, Mich.: Baker Books, 1972), 1-36.
Although there are areas of considerable overlap, notable differences exist with regard to biological psychiatry between Adams himself and the contemporary CCEF. Adams’ Institute for Nouthetic Studies continues to publish, under the title “The Christian Approach to Schizophrenia,” an essay by Adams originally published in 1976 which sets forth a highly volitional account of the bizarre behavior of schizophrenia (“It is altogether possible that the chemical/electrical processes that govern perception [in schizophrenia] may be controlled by an attitude, etc., in a manner that makes man more responsible for these functions than most have thought”), which views even “organic” elements in schizophrenia to be a direct result of the fall, and yet which leaves room for medical intervention for these “organic” elements:

_Schizophrenia_ is a psychological or psychiatric label which leads toward psychological or psychiatric solutions. If, on the other hand, investigation shows that a particular kind of bizarre behavior should be labeled as a chemical malfunction (stemming not from personal sin such as sleep loss, but is rather solely the result of the fall), that conclusion leads toward a medical solution. If it indicates that the problem comes from sinful living, the term “sin” points in the direction of a theological solution . . .  

Despite this conceptual openness, however, Adams’ own writings are on the whole quite skeptical of psychiatry in any form, and expressly opposed to the use of psychiatric drugs unless clear etiologic “organic” factors for mental disorders have been identified.  

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In contrast to Adams, writers associated with the CCEF wing of the biblical counseling movement have tended to set forth more pragmatic views regarding the use of psychiatric medication. Although these writers (principally David Powlison and Edward Welch, both affiliated with the CCEF) remain committed to the sufficiency of scripture as a guide to pastoral practice, the unquestionable authority of the church (and its pastors) over contemporary systems of psychotherapy and psychiatric practice, the consistent avoidance of any biological reductionism, and the central role of the sinful human “heart” in the generation of human suffering, their essential views regarding psychiatric technology are – somewhat surprisingly – similar in many ways to the previously-surveyed views of many pastoral care and integrationist thinkers. Welch’s *Blame It On the Brain?* is pervaded, as its title indicates, by the concern that neuroscience is too often invoked in a way that enables the avoidance of moral responsibility for behavior, but he argues nonetheless that the body routinely “imposes limitations on the desires of the heart” and that, in some cases, mental disorders like depression can be

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“caused by bodily weakness.” Although the brain cannot cause anyone to sin, and although neither psychiatric diagnosis nor psychiatric treatment should function in such a way as to excuse sinful behavior (even, for example, in someone who is brain-injured or demented), Welch nonetheless supports the prudent use of psychiatric medications to “alleviate some of the physical symptoms associated with some psychiatric problems,” even if the medications are not treating any known “chemical imbalance.” Medication should not be used as a first-line therapy without counseling or used to eliminate all suffering – “there can be real benefits from having our faith tested and strengthened through trials” – but nonetheless “the alleviation of suffering is a good thing,” and the Bible does not expressly prohibit the use of psychiatric medication. These general principles apply not only to the treatment of depression but also to many other psychiatric disorders, though not for alcoholism, which should not be narrated under any disease

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103 Ibid., 108-109.
model. David Powlison, acknowledging the resurgence of biological psychiatry in the 1990s, warns readers that “what the Bible says about people will never be destroyed by any neurological or genetic finding” and that contemporary biological psychiatry, like all psychiatric trends, will eventually pass, but nonetheless acknowledges “some real and fascinating knowledge” in contemporary neurobiology and advocates ultimately a prudent and pragmatic stance toward the use of medication: counseling is always indicated but medical treatment should in some cases be combined “flexibly and in various proportions.”

We see, then, that while the biblical counseling movement is frequently associated with Szaszian antipsychiatry and a counseling method informed by scripture alone, both of the major contemporary streams of the movement have proved open to certain aspects of biological psychiatry: Adams through his realist assertion that “organic” causes of illness, including mental illness, should rightfully be treated by physicians; and the CCEF writers through their additional consensus that psychiatric medication may in some cases be used to alleviate suffering even when there is no clear organic abnormality to be treated.

1.2.4 Biological Psychiatry in the “Christian Psychology” Movement

The first three movements surveyed in this brief overview – modern pastoral care, evangelical integrationism, and biblical counseling – are at least several decades old and

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have developed substantial clinical, organizational, and academic infrastructures which support large numbers of counselors and clinicians who consider themselves adherents of their respective movements. Neither of the final two – “Christian psychology” and the Catholic-centered movement associated with the Institute for the Psychological Sciences—have attained this level of organizational maturity. Both are still emerging as communities of discourse and, as reform-and-renewal movements, share a commitment to a more robust and tradition-centered theological account of psychology than has traditionally been the case (they allege) within the first three movements. Eventually, these movements may become sufficiently interdigitated as to warrant a unified conceptual account: the faculty of the IPS recently guest-edited an issue of the Society for Christian Psychology’s fledgling academic journal Edification (Vol. 3., Issue 1, 2009, “Catholic Psychology”) and important contemporary voices such as Paul Vitz are associated with both. There are enough important differences between them, however to consider each in turn.

The “Christian psychology” movement is largely, though not exclusively, formed of evangelical scholars, pastors, and clinicians who are dissatisfied with the interminable intra-evangelical debates between integrationists and biblical counselors and who desire a more fundamental rethinking of psychology in Christian terms than either integrationists or biblical counselors have historically pursued. More than any of the four other movements considered here, it is largely an academic and ideological, rather than a clinical, movement, anchored by a few key thinkers and texts (to be considered below), a recently formed umbrella organization known as the Society for Christian Psychology
(SCP; www.christianpsych.org), and the academic journal *Edification: The Transdisciplinary Journal of Christian Psychology*. It is not (yet) associated with any independent academic institutions or training programs and is therefore best still considered as a reform movement within integrationism and (to a lesser extent) biblical counseling.

In a programmatic essay attempting to distinguish Christian psychology from the two existent evangelical movements, Robert C. Roberts offers the following:

The integration model is compelling if we accept the establishment view of what psychology is. But if we take a broader historical perspective, it is clear that what the psychological establishment calls psychology is not the only thing that might justifiably go by that name. If we look closely at the alternatives, it is almost as clear that what the establishment calls psychology, while it has made significant contributions to our understanding of human nature and functioning, is not always superior to other kinds of psychology that have been offered from time to time in history. It seems clear to me, for example, that while the twentieth-century behaviorist school and its softer, more “mind”-friendly successors have taught us some important things about human susceptibility to conditioning, the account of human action offered in Aristotle’s *Nicomachean Ethics* . . . is superior to anything that twentieth-century style of inquiry has produced.”

Roberts then cites a long line of pagan and Christian voices across time – Chrysippus, Aquinas, Austen, Dickens, Eliot, Dostoyevsky, Tolstoy, Evagrius Ponticus, Cassian, Augustine, Baxter, Edwards, (especially) Kierkegaard – who deserve serious consideration for their psychological views. “Our task as Christian psychologists,” he writes, “is in large part to retrieve the Christian psychology of the past, understand what these writers have to say, sift it for what has enduring Christian importance and present it

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to our contemporaries in a form that can be understood and used.”

Insofar, then, as “Christian psychology” can be differentiated from the more established evangelical movements, it is characterized by a commitment to engage not only the internal logic of scripture (which remains always primary) but also seminal theological and psychological voices in Christian tradition in order to engage modern psychology and psychiatry and, ultimately, to construct a pervasively Christian contemporary psychological view. As such, the writings of the movement tend to provide deeper engagement with philosophy and theology than one often finds in the integrationist and biblical counseling literature.

Eric Johnson is one of the key figures in the Christian psychology movement, and his *Foundations for Soul Care: A Christian Psychology Proposal*, clearly aimed at an evangelical protestant readership, provides so far the most sustained articulation of Christian psychology to date. It is worthwhile to recount Johnson’s basic proposals in the book *en route* to considering his specific treatment of biological psychiatry. Johnson begins by stating that a distinctively Christian psychology would be doxological (“it ought to aim to interpret and conduct everything in order to best foster the human appropriation and manifestation of the glory of God”), semiodiscursive (concerned with meaning expressed in signs, utterances or texts, and therefore “unavoidably

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109 Ibid., 153.
110 See Robert C. Roberts and Mark R. Talbot, eds., *Limning the Psyche: Explorations in Christian Psychology* (Grand Rapids, Mich.: Eerdmans, 1997). As is made clear, however, by the nuanced debate recorded in Johnson and Jones [ed], *Psychology and Christianity* and Eric Johnson’s charitable and careful discussion in *Foundations for Soul Care*, categorical claims regarding differences between Christian psychology and either biblical counseling and integrationism are often dangerously oversimplistic.
hermeneutic”

dialogical/”trialogical” (situated in a matrix of conversation between
the counselor, the counselee, and God), “canonical” (by which Johnson means informed
by scripture), and psychological (concerned with “the nature of individual human beings
and their psychopathology and recovery”). Although under the condition of present
life the soul is “thoroughly brain-dependent,” nonetheless “both soul and brain are
characterized by semiodiscursiveness, that is, somehow brain and soul are both a function
of the speech of God.”

After an extended methodological introduction in which he
affirms a commitment to Reformed thought, including a commitment to the authority,
necessity, and sufficiency of scripture as a guide to faith and practice, as well as an
appreciation for empirical scientific inquiry guided by Christian metaphysical
presuppositions, Johnson posits a model of human life comprised of four
“semiodiscursive orders” – the biological, the psychosocial, the ethical, and the spiritual
– “which in the mind of God together form a single, coherent ‘text’ of a human being – a
living text (a letter, 2 Cor. 3:3) being written by the Spirit to experience and to express
God’s glory.”

God’s glory is displayed in God’s rightly-oriented created signs.

Johnson proposes an integrated model of these four orders, in which interventions or
changes at one order frequently, if not always, impact the others. In a rightly-directed

112 Ibid., 14.
113 Ibid., 16.
114 Ibid., 17.
115 Ibid., 261. The Kierkegaardian distinction between the psychosocial, the ethical, and the spiritual (or
religious) should be evident. The biological order is “uniquely foundational to human life as we know it”
and “provides the material platform for all higher psychological functioning” (336). The psychosocial
order refers to the “immaterial dynamic structures that originate in social interaction but are gradually
internalized within the individual human being, developing throughout life and giving definition and
dynamic form to the embodied human” (337). The ethical order is concerned with personal agency,
conscience, creativity, neighbor-love and communality, capacity for virtue, and recursive/evaluative
narrative awareness (341-3). The spiritual order is concerned with the divine and with the person’s location
in divine salvation history.
life, all four of these semiodiscursive orders are doxologically oriented to the manifestation of God’s glory. However, because the lower strata (e.g., the biological) ground the higher strata, “the higher strata can only arise if the lower strata have properly developed and are properly functioning.” When this occurs, however, the features of the lower strata are meant to be subsumed into the higher, more significant strata, “until all are subsumed within the spiritual order.” This leads Johnson to posit four “rules of intervention” for Christian soul-care providers. Christian soul-care providers, he argues, (a) are free to work at all levels but, due to the hierarchy of the four orders, should work (b) at the highest level possible and (c) at the lowest level necessary, seeking always (d) to transpose lower level activity into the spiritual order. This then enables Johnson to engage in extended discussions of participation in Christ and the trinitarian ground of Christian soul-care, self-examination and inwardness, psychopathology, and Christ-formed sanctification.

Engaging modern psychiatry, Johnson argues that from the standpoint of Christian psychology, psychopathology is “any internal barrier to a person’s manifestation of God’s glory,” and that it “ought to be defined as any psychospiritual aberration from the form of the Christ of the canon.” Under this (quite broad) conception of psychopathology, barriers can be identified in each of the four orders, including (at times) genetic, neurobiological, and chemical determinants in the biological order. Because of this,

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116 Ibid., 363. Johnson is careful to state that this does not entail a biological reductionism, since “all the orders are themselves grounded in the Son of God’s providential support” (363).
117 Ibid., 366.
118 Ibid., 382.
119 Ibid., 459.
drug treatments and other forms of biological intervention are necessitated when semiodiscursive adjustments at the higher orders are ineffective. Lower-order interventions ought not to be despised by Christians. Biological remediation too is a gift of God and should be received with gratitude, sanctified as it is by the word of God and prayer. Sometimes it is necessary to make temporary, neurochemical changes in the brain so that more enduring changes (new neural networks) can be attained. Nonetheless, the limitations of biological intervention must also be acknowledged, since an exclusive reliance on the use of medications only deals with the biological symptoms and does not lead to long-term structural changes either at the neuronal level or the higher spheres. It should always be assumed that biological interventions will only be used in conjunction with higher-order therapeutic work, and only for as long as necessary, to help the counselee develop theocentric higher-order structures that can generate and maintain the desirable biological conditions on their own, ideally without medication.

In Johnson’s proposal, then, we see a cautious acceptance of the use of psychiatric technology to alter biological/neurochemical “determinants” in order to encourage the doxological orientation of the person.

1.2.5 Biological Psychiatry in the work of the Institute for the Psychological Sciences

Although Catholics have long interfaced with clinical psychiatry both as patients and as practitioners, although some of the most influential American psychiatrists have been practicing Catholics, and although Catholic moral and ascetic theology has traditionally accommodated modern psychiatric research and practice with little overt friction, psychiatry and clinical psychology per se have not historically been major foci of magisterial teaching or attention. Although Pope Pius XII assured psychotherapists and clinical psychologists that “the Church follows your research and your medical

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120 Ibid., 491.
practice with her warm interest and her best wishes”¹²³ and Pope John Paul II in 1993 balanced ostensive praise of psychiatrists with the admonition that “no adequate assessment of the nature of the human person or the requirements for human fulfillment and psycho-social well-being can be made without respect for man’s spiritual dimension and capacity for self–transcendence,”¹²⁴ one looks nearly in vain for a sustained engagement with either psychology or psychiatry in a papal encyclical or any other definitive magisterial teaching. Exceptions to this include the brief treatment accorded to “psycho-pharmaceuticals” and “psychology and psychotherapy” in the 1995 “Charter for Health Care Workers” issued by the ad hoc Pontifical Council for the Pastoral Assistance of Health Care Workers, which balances respect for the medical model of psychiatry with concern about the side-effects of psychiatric medication, concern for their abuse potential, and concern about their use for enhancement purposes, but which could not be considered a deep conceptual engagement.¹²⁵ In addition, the pastoral care, integrationist, and biblical counseling movements in the United States arose out of protestant theological and ecclesial concerns and have been largely (exclusively, in the case of biblical counseling) dominated by protestants.

This apparent gap in sustained Catholic engagement with modern psychology has been attenuated since the late 1990s, in the American context at least, by the ambitious work of the newly-formed Institute for the Psychological Sciences (IPS) in Arlington, Virginia (www.ipsciences.edu). Financially supported by the Legionaries of Christ and led by Catholic psychologist (now academic dean) Gladys Sweeney, the Institute (now a regionally accredited graduate school of psychology) has recruited multiple “magisterium-faithful” Catholic psychologists, theologians, and philosophers for its faculty and has sponsored several academic and publishing initiatives. As a result, though still in its institutional adolescence, the work of the IPS represents a distinguishable alternative (despite considerable overlap) to the movements described so far and therefore deserves independent mention. As I will be engaging more substantially with many of the central concerns of the IPS scholars in Part Two of this work, I provide only a cursory overview here.

One notable difference between the work of the IPS and the other motives, unsurprisingly, is its heavy engagement with theological and philosophical systems important for Catholic thought but traditionally neglected in protestantism, especially Thomism and the Christian personalism of Karol Wojtyla/John Paul II. Aquinas had

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126 The Legion’s controversial presence within the contemporary church, as well as its internal upheaval regarding posthumous revelations regarding the life of its founder Fr. Marcial Maciel, are beyond the scope of this brief review.

127 It should be noted that not all work associated with the IPS is done by its current faculty. Some, like Christian Brugger, have left for other academic positions; others, like Benedict Ashley, have been senior advisors to the program; still others, like Fergus Kerr, have visited the IPS for sabbatical or other short-term work and may not identify with certain aspects of its overall mission. It should be noted also that Ashley’s, DeBlois’, and O’Rourke’s Health Care Ethics: A Catholic Theological Analysis (Washington, D.C.: Georgetown University Press, 2006), now in its fifth edition, dedicates a few pages to psychiatric medication in which they issue the standard warnings against either total reliance on or total avoidance of psychiatric medication; this work long preceded Ashley’s involvement with the IPS.
surfaced surprisingly little in the modern Christianity-and-psychology literature, but the IPS-related work has substantially increased St. Thomas’ exposure. E. Christian Brugger, in particular, has written several articles in the integrationist and Christian psychology literature arguing for (his interpretation of) a Thomistic account of hylomorphic body-soul unity, volitionality and freedom, and teleology. Craig Steven Titus and others have written at length on the implications of Thomistic moral psychology, and in particular St. Thomas’ account of the passions and the virtues, for contemporary psychological treatment of action and emotion.

The IPS is a graduate school of psychology and, like the evangelical integrationist movement, is principally focused on and engaged with questions posed by modern psychology; it is less focused on issues proper to psychiatry. Whether for this or other reasons, biological psychiatry has never emerged as a central focus of the work of any of the scholars associated with the IPS.

Although not affiliated with the IPS, two recent publications by Catholic moral and psychological thinkers have addressed the appropriate use of antidepressant

medication. Stephen Loughlin provides a close reading of Thomas Aquinas’ conceptions of tristitia (sadness) and dolor (pain) in the discussion of the passions in the Summa theologiae (a discussion we will consider in more detail in Chapter 8), arguing that Aquinas’ intricate analysis provides a helpful resource for analysis of modern depression, not only in its hylomorphic understanding of the body and soul but also in its analysis of the causes of tristitia and in its insistence that tristitia is neither reducible to the body (as in materialism) nor unrelated to the proper operation of the mind (as in some post-Cartesian modern thought). Considering Aquinas’ inclusion of “sleep and baths” among appropriate treatments for sorrow, Loughlin offers a “broader perspective” that “in addition to sleep and baths, one might add exercise, good clean air, pure water, a good diet, therapeutic massages, and varied forms of entertainment to the list, anything that addresses the body and helps it with the demands placed upon it by the experience of sorrow.” In addition, he states, there are “whatever medications available that effect a balancing, in Thomas’ terms, of the humors, or, in our language, of the chemistry and biological processes involved in our affectivity.” Such medications could well be licit, but Loughlin is cautious:

[The] fact still remains that Thomas would consider a drug targeting the very center of the body’s involvement with sorrow as a particularly strong mitigating factor of sorrow’s effects, but still as something which addresses only the symptoms, and not sorrow’s underlying causes. The remedy for sorrow, in Aquinas’ view, is not a material one. Rather, it is one that must address importantly our very humanity, both in itself and in relation to the way by which we perfect this through our living.

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132 Ibid., 775.
133 Ibid., 776. Loughlin’s analysis of Aquinas on tristitia, which I encountered only while making final revisions to this dissertation, is consistent in many ways with the reading of Aquinas which I offer in
Loughlin’s analysis is expanded and given book-length treatment by John-Mark Miravalle (also not affiliated with the IPS), who draws on various critics of biological psychiatry (e.g., Peter Breggin and David Healy; see Chapter 2) to argue that no convincing evidence currently exists for the biological causation of major depression and that all current antidepressant therapies are palliative, rather than curative, in nature. Miravalle makes clear that some palliative uses for antidepressants might be licit for Catholics, but urges great caution. Invoking the encyclicals *Humanae vitae* and *Familiaris consortio*, he argues that just as contraception is illicit because it robs sexuality of its proper end of procreation, so also “nor... are the personal functions of the emotions, specifically sorrow, to be disfigured or robbed of their proper ends.”

Specifically, he argues, antidepressants can separate the appetitive from the apprehensive powers of the human soul just as contraceptives can separate the procreative and the unitive ends of sexual intercourse. For the Christian, he argues, suffering may well be a gift of grace intended for the sanctification of the person; to efface this by means of technology would perhaps be to refuse a divinely offered gift. For this reason, he argues, Catholics should approach antidepressant use with extreme caution, though he allows that they may occasionally be helpful in order to remove obstacles to psychological treatment:

Chapter 8 of this work, and I agree wholeheartedly with his caution. In my view, however, as articulated in much more detail in Chapters 2, 4, 8, and 9, it is a mistake to speak of the “balancing” of “the chemistry and biological processes involved in our affectivity” as a standard for the appropriate use of antidepressants or other psychiatric technology, since no standard exists by which to recognize “balance” without resorting to extra-biological criteria of judgment. The language of “balance,” both for Aquinas and for modern clinicians and patients, is a metaphor which opens itself outside of the proper realm of biology.

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135 Ibid., 54.
“antidepressants should be used only to the extent that they facilitate treatment of the underlying psychological base of the ailment.”

1.3 Toward a Teleological Christian Paradigm for the Use of Psychiatric Technology

Even this cursory overview of five American Christian communities of discourse surrounding the relationship of psychology and theology reveals a dramatically fragmented and disunified field in which the major movements lack any common vision and any common forum for debate and are all too often deaf (and perhaps blind) to each other. Furthermore, many of the movements surveyed in fact are comprised of divergent and sometimes combative sub-communities which make any taxonomic generalizations treacherous and overly simplistic. My overall aim in this work is not to provide a comprehensive overview of these movements, nor to critique each in chapter-length detail, but rather to offer a Thomistic account of the Christian use of psychiatric technology which is accountable to all of them – sometimes challenging, sometimes affirming, and hopefully always, if I am successful, clarifying and edifying. At the risk

136 Ibid., 80. As with Loughlin, my constructive analysis in Chapter 9 also bears similarity to that of Miravalle due to our common grounding in the texts of Aquinas. I particularly agree with his conclusion that “palliative” use of antidepressants may be helpful to the extent that they are able to facilitate meaning-oriented psychotherapy in those who are so incapacitated by depression or other mental disorders that they are unable to engage in meaning-oriented work. My argument here differs from that of Miravalle, however, (a) in its critical account of psychiatric nosology, which Miravalle takes as a given and therefore misses opportunities for engagement and (b) in its refusal to split the sources of depression or any other mental disorder into “biological” and “psychological” categories as Miravalle does. I am also more cautious than Miravalle about assigning redemptive or pedagogical value to the suffering of others, and I am unconvinced that his comparison of antidepressants and contraceptives is apt, primarily because it overestimates the actual power of currently available antidepressants, which may (or may not) modify but certainly do not sunder the relationship of the passions to the apprehensive powers of the person. Miravalle also does not address questions of psychosis, including depression with psychotic features; such consideration would render his use of Humanae Vitae much more problematic.
of oversimplification, I will name several common threads within the existing movements toward which my account is critical, and on which it seeks to improve.

The first and most glaring problem with contemporary Christian engagement with biological psychiatry is, quite simply, its scarcity. Despite increasing use of psychiatric medication in the American public and despite (or perhaps because of) increasing public acceptance of its use, most contemporary Christian writing regarding psychiatric technology has taken the form of scattered journal articles or brief and cursory commentaries in books more properly oriented toward clinical psychology. But more can, and should, be said, and I hope to offer a more sustained theological reflection than has appeared in the various literatures to date.

The second problem with contemporary Christian engagement with biological psychiatry is inappropriate deference to physicians and trust in the medical model of psychiatry, the common belief that psychiatry – and in particular biological psychiatry – can internally sustain its own practice through the bioscientific methods available to it. This kind of view, as shown above, is commonplace in several of the movements described above. Its continued existence, however, even as in Jay Adams’ assertion that the pastor should work “back to back” with the physician, reinforces a misleading fact/value dichotomy between medicine and theology which renders opaque the degree to which medical practice, and particularly psychiatric practice, is already unintelligible apart from particular teleological “values.” Once this is established, it becomes clear that the psychiatrist qua psychiatrist has no particular authority to distinguish “mental disorder” from “mental health,” and therefore to decide who would and who would not
potentially benefit from psychiatric medication, except insofar as he or she is formed by a particular moral community (or communities) which inform some vision, however inchoate, of a properly lived human life.\footnote{The psychiatric profession itself, with its various modes of training and self-regulation, can serve as one such moral community; but in this event, it must be evaluated as a moral community and not as an “objective” bioscientific one.} The entire first part of this work ( chapters 2-5 ) is devoted to showing why, on grounds internal to psychiatry, this is the case. In chapter 2, I argue that neurobiology and empirical science alone cannot ground the practice of psychiatry because it cannot supply an account of dysfunction sufficient for the specification of “mental disorder.” What is needed, I argue, is a philosophy of disease which neurobiology cannot supply on its own. Understanding psychiatric disease classification (psychiatric nosology), I argue, requires attention not only to empirical science but also to the history and philosophy of psychiatry. In chapter 3, I use Alasdair MacIntyre’s typology of forms of moral inquiry, as set forth in \textit{Three Rival Versions of Moral Enquiry},\footnote{Alasdair MacIntyre, \textit{Three Rival Versions of Moral Enquiry: Encyclopaedia, Geneaology, Tradition} (Notre Dame, Ind.: University of Notre Dame Press, 1990).} to argue that psychiatric nosology is best conceived not as MacIntyrean “encyclopedia” but, rather, as a tradition-constituted discourse. In chapter 4, I argue that psychiatric nosology displays some conception of the proper human \textit{telos}, even if this conception is socially and politically uncontested and therefore unacknowledged among practitioners: “disease” or “disorder” is correlative to “health,” and “health” is correlative to some conception of the well-lived human life which can only be understood in the context of particular forms of moral community. Defining health and disease, therefore, is an inextricably ethical and communal task. In chapter 5, I argue, by way of the example of Post-Traumatic Stress Disorder, that psychiatric...
nosology is practically important not only because it guides the use of psychiatric technology but also because it constructs the experience (and, correlatively, the moral valuations) of those so diagnosed.

The loss of the traditional medical model as a regulatory guide to the identification of mental disorder and the application of psychiatric technology creates space for alternative conceptual accounts of when the use of psychiatric technology is, and is not, appropriate. But these conceptual accounts—accounts of theological anthropology, for Christians—must be robust and complex if they are to avoid either gnostic categorical rejection of psychiatric medication or uncritical acceptance of it. Many of the *au courant* theological models, in my judgment, rightly reject Cartesian and Platonic dualism but too quickly embrace an *absolute* body-soul unity (e.g., Boiven’s [2003] “Hebraic model” and Murphy’s “nonreductive physicalism”139) and therefore inappropriately compromise their ability to bracket the use of somatic technology for disorders of the body, since they provide no real account of the soul apart from the body and the mind/body or soul/body distinction becomes increasingly trivial. These accounts tend to equate psychopathology with any form of human brokenness, and therefore tend to accept *in principle* the use of medication for severe brokenness of any sort if other higher-level interventions (such as psychotherapy) seem not to be working. The non-dualistic effort to emphasize the body’s union with the soul paradoxically leads to an anthropological monism in which the body *qua* body is less and less relevant.

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139 cf. Nancey Murphy, *Bodies and Souls, or Spirited Bodies*?
In Part Two of this work, I offer the anthropology and moral theology of St. Thomas Aquinas as a conceptual resource for Christian engagement with biological psychiatry. A Thomistic anthropology, I will argue, does not eliminate all complexities related to the use of psychiatric technology, but it does provide considerable conceptual power. Aquinas, I will show in chapters 6 and 7, offers an account of body and soul in which the body is hylomorphically united to the soul and yet not equivalent to it; this provides the resources for providing an account of the body’s proper function without devolving into either a Cartesian dualism (which is rendered untenable within modern psychiatry) or a body-soul monism which equates bodily health with beatitude. Consistent with this, Aquinas offers a nuanced account of the relationship of the body to the moral agency of the person, explored in chapter 8, which links his metaphysical biology to his moral theology in interesting and illuminative ways.

As I will argue in much more detail in chapter 8, “health” (sanitas) for Aquinas is a habit – later called an entitative habit by his commentators, to distinguish it from operative habits such as the moral virtues – which disposes the body to its form; health, in other words, is a description of a body which is functioning as bodies are supposed to function. For Aquinas, human bodies are supposed to function in such a way as to support the pursuit of the well-lived life, specifically through the vegetative functions (nutrition and growth) and the sensory functions (sensation, perception, memory, and emotional processing adequate for engagement with the person’s world) which provide the conditions of possibility (in bodily life) for the reason and will to function properly.
It is important to note that such health can be had, in theory, whether or not the reason and will are in fact functioning properly, and also whether or not the person has been gifted with the divine sanctifying grace which is a necessary condition for the attainment of beatitude. Bodily health is, therefore, not beatitude. However, any attempt to describe health apart from consideration of beatitude is bound to fail, since no one – even Aquinas himself, despite his adherence to Galenic four-humor physiology – has any epistemological access to the clear description of health apart from the proper operation of the human person. Therefore, although health is not beatitude, health can only be known for Christians in the light of beatitude, and for all other moral communities in the light of their best understanding of life-at-its-fullest. Christians therefore understand health retrospectively as that ordering of the body which enables the reason and will, which rely on the body for information and execution, to function reliably. “Disease” or “disorder” names either the absence of this proper ordering or a condition which will, predictably, lead to such an absence if preventative measures are not utilized. This is not to say, of course, that bodily health is a necessary condition for beatitude; the paradox of the Christian gospel is that while bodily health may be pursued and valued as a proleptic expectation of eschatological bodily integrity, bodily health may also become an idol which, instead of anticipating the eschaton, leads to the progressive involution of the self upon itself. Conversely, while Christians may validly detest disease or disorder

140 Hypertension does not per se prevent the reliable function of the reason and will, but myocardial infarction can; because hypertension predictably leads to myocardial infarction in a subset of persons, it can validly be called a disease or disorder and may therefore be treated somatically.
and may validly utilize medical care to avoid or to cure it, it is often through disease and disorder that God’s grace is manifest both to the person and the community.  

As I will argue in chapters 7 through 9, Aquinas offers a sensitive analysis of the relationship of the body to the moral agency of the person which provides a framework for the identification of bodily disease/disorder in which the use of psychiatric technology might be appropriate. The principal teleological roles of the body with regard to the will and intellect, for Aquinas, are to supply the intellect with accurate representations of the world, to provide the material infrastructure for the intellect’s and will’s function, and to execute the will’s commands. If any of these functions are corrupted, I will argue, there might be appropriate warrant for the use of psychiatric technology, if any extant technology (i.e., medication) would help. But this, too, is a slippery slope which requires careful and prudential judgment. Sometimes, when a bodily defect is clearly present due to the identification of a destructive or degenerative causal mechanism (e.g., the spirochete *Treponema pallidum* in tertiary neurosyphilis), the use of curative or remediating technology (e.g., penicillin) is unambiguously justified. But most of the time, in contemporary psychiatric practice, this is not the case: the symptoms which bring persons into treatment either do not have clearly identified biological causes, or any identified factors are part of complex biological-environmental webs which themselves do little more than confer vulnerability to particular kinds of environmental injury. In these cases – which is most of the time – the use of technology must be a matter of

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141 The challenge for “disability theology,” considered in more detail in Chapter 8, is to maintain this paradox without resolving it.
142 In this respect, I will argue that although the rational faculty of the soul does not depend on the body for its function and is therefore incorporeal, nonetheless cognition is, for Aquinas, an embodied activity.
clinical prudence, in which the goal of therapy is not to reverse or cure but rather to enable the body, as much as possible, to perform its proper role with respect to the function of the will and intellect. The guiding question for Christians contemplating the use of psychiatric medication is, therefore, not “Will this reduce his/her/my distress?” or “Will this improve his/her/my performance?” but, rather, “Will this render the pursuit of virtue more or less possible for him/her/me?” Psychiatric technology is justified, in this case, only if the answer is clearly and unambiguously: “more.”
Part One:

Toward a Traditioned, Teleological Account of Psychiatric Nosology
2 What Counts as Mental Disorder? The Contested Languages of Modern Psychiatric Nosology

The medical model of psychiatry – the conceptual and linguistic system in which various forms of human experience are considered under the description of illness, disease, disorder, diagnosis and/or therapy – exerts a powerful influence on discussions about appropriate uses of psychiatric technology both within the various theological communities surveyed in the last chapter and also within broader cultural conversations. In the last chapter I noted, with some surprise, that the five surveyed American Christian communities of theological engagement with psychiatry (the pastoral care movement, integrationism, biblical counseling, “Christian psychology,” and the work of the Institute for the Psychological Sciences), despite considerable differences in their approach to psychoanalysis and to clinical psychology, have historically devoted comparatively little energy to critical engagement with biological psychiatry and have generally deferred judgment about biological models within psychiatry to medical and scientific experts. But this, I argued, is short-sighted, because biological psychiatry does not pertain to empirical science alone.1 It also carries within itself a history and a politics; or, more specifically, a history of politically-derived philosophical and practical commitments which have given rise to particular forms of research, have guided its interpretation, and have governed its application to clinical practice. Biological psychiatry is unintelligible apart from the practical and philosophical commitments of its originating communities –

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1 I do not wish to suggest, in this chapter or elsewhere, that neurobiology or empirical science is “value-free.” I am convinced by the work of Michael Polanyi and others that it is not; however, because my work here pertains to the clinical practice of psychiatry rather than to neurobiology per se, I do not engage those arguments here.
and this should matter for Christians seeking to make sense of the complicated landscape of the psychiatric technologies.

This chapter, and the two chapters following upon it, are intended as an internal exposition and exploration of the medical model of psychiatry, using grounds of argument which are not specifically theological and which are therefore accessible to those with or without specific theological or religious commitments. In this chapter, I will explore recent and contemporary conversations within psychiatry and philosophy of psychiatry regarding psychiatric disease classification and the medical model. This analysis will reveal that five decades of engagement with anti-medicalization critics has resulted not in a clear exposition and defense of a value-neutral “scientific” psychopathology but rather in a growing consensus that psychiatric diagnosis and disease classification is in fact permeated by the sociocultural and moral “values” of clinician and patient alike. In Chapter 3, I will introduce Alasdair MacIntyre’s work in order to argue for a tradition-centered account of psychopathology; and then, in Chapter 4, will argue for an account of psychopathology which is explicitly teleological.

2.1 The Inability of Neurobiology to Ground Clinical Practice

Lost amid contemporary popular enthusiasm for biological psychiatry is the simple and often-observed truth that considered as a clinical practice, biological psychiatry is heavily informed by neurobiology but is not comprehensively directed or
determined by it. Neurobiology, that is, despite its considerable investigational utility, cannot provide a satisfactory account of the proper use of the specific psychiatric technologies which it births without recourse to normative concepts which are, properly speaking, not part of neurobiology. This is primarily because it cannot provide intrinsic accounts of which neural states of affairs should be considered “mental disorder” and which should not.

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2 An initial clarification of terms is in order. In the discussion that follows, and throughout this work, I will use the term “neurobiology” to denote the scientific investigation of the brain and nervous system. In this narration, neurobiology is conceptually distinct from psychology, the science of behavior and mental phenomena. Because of this, it is a narrower and more methodologically distinct term than “neuroscience,” which is often used interchangeably with neurobiology but which, in contemporary academic work, is used to describe a wide array of disciplinary approaches to brain and mind, including not only biology but also cognitive science, computer science, linguistics, mathematics, philosophy, and developmental psychology, as well as clinical disciplines such as neurology, psychiatry, and medicine. This broad use of “neuroscience” renders it excessively nonspecific for my purpose here, and so for that reason I will not employ it. But the methodological pluralism characteristic of modern “neuroscience” renders contestible any effort to distinguish neurobiology from psychology on methodological grounds. “Neuropsychology,” for example, is both a research and clinical discipline of psychology which is keenly attentive to the brain and nervous system – so attentive, in fact, that it deserves to be noted as an auxiliary discipline to basic neurobiology, providing detailed investigation into the psychological and phenomenal correlates of brain and neural function. Furthermore, mental phenomena such as sensations and perceptions are inextricable from the methodology of much basic neurobiological work, e.g. Hubel’s classic work on the cellular architecture of the brain’s visual pathways.

Despite these fluid boundaries, a conceptual distinction between “neurobiology” and “psychology” is important for the present discussion as a means to narrate what differentiates biological psychiatry from other forms of psychiatric practice. The brain and nervous system, for biological psychiatry, is a necessary object of attention; a form of psychiatric practice for which this does not hold would, in ordinary language, cease to be considered “biological psychiatry,” just as any forms of neuroscience for which the brain and nervous system were not necessary objects of attention (computer modeling of artificial intelligence, for example) would cease, in my account, to be “neurobiology.” In this way, neurobiology is the scientific discipline most basic to the clinical and practical movement of “biological psychiatry,” in that it is neurobiology which makes biological psychiatry “biological” in its ordinary usage.

Defined in this way by its necessary object, “neurobiology,” while more specific than “neuroscience,” is still a broad term encompassing a variety of scientific disciplines. For the purposes of this account, I use the term “neurobiology” to include (1) basic neurobiological disciplines such as neuroanatomy, neurophysiology, and neural development/neuroembryology, (2) foundational disciplines such as molecular and cell biology, physics, and chemistry which are necessary for understanding the biological function of the brain and nervous system, (3) biological investigation into extra-neural systems, when done in the service of understanding brain and nervous function (e.g., research on sex hormones or stress hormones and neurodevelopment), (4) psychiatric and neural genetics, and (5) “auxiliary” disciplines (such as neuropsychology) dedicated to exploring the phenomenal and behavioral correlates of normal and abnormal neural and brain function.
This is a strong claim which is – as described later in this chapter – hotly debated by contemporary philosophical commentators on psychiatry, but it is nonetheless rare to find any exponent of biological psychiatry who would offer explicit argument to the contrary. Even the Society for Biological Psychiatry, the movement’s primary professional organization, emphasizes in its mission statement that “the term ‘biological psychiatry’ emphasizes the biological nature of behavior and its disorders and implies the use of the medical model; but in so doing, it encompasses other major areas of modern psychiatric medicine, including its humanitarian mission, psychological foundation, and socio-cultural orientation.” Biological psychiatry, in other words, is not a solely neurobiological endeavor.

That neurobiology does not supply the practical ends for the application of psychiatric technology is nearly self-evident for any observer of modern psychiatry. Biological psychiatry conforms cleanly to what Joseph Dunne, describing Aristotle’s concept of techne, refers to as the “technical project of modern medicine,” in which (a) the end/goal of a particular clinical encounter is specified in advance of the application of a particular “method” or “technology,” (b) the focus is instead on the selection of the method or technology which best attains this pre-specified end, and in which (c) the successful application of the method or technology does not depend on the moral

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character of the agent. But we must ask: can neurobiology supply the practical ends necessary to ground clinical decision-making?

What would be necessary in order for neurobiology or its auxiliary disciplines to provide sufficient ends for the practice of biological psychiatry? At a minimum, a neurobiological account of proper brain and nervous system function should be articulable without reference to extra-biological criteria of judgment. Neurobiology alone, that is, should be able to provide an account of how one would differentiate a properly functioning brain (and nervous system) from a malfunctioning brain (and nervous system) with regard to the human capacities – of cognition, emotion, and will, for example – which constitute the usual domain of psychiatry.

It is clear that modern neurobiology, like modern biology in general, is permeated by functional concepts. The structure and function of the neuron in its various forms, for example, has been intimately described within neurobiological research: although there is much that is still not understood and new knowledge is still being produced at a staggering rate, contemporary neurobiology offers robust descriptions of what neurons are, how they are constituted (with lipid membranes, voltage-gated ion channels, and so on), and what they are for (among other things, to conduct electrical signals). When a particular set of neurons are found, for example, to be unable to discharge particular chemicals through synapses in the way that neurons characteristically do despite apparently appropriate stimulatory input from other cells, neurobiology can recognize

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that this represents a deviation from proper function and can provide methods to investigate why the neurons are functioning incorrectly (as a result of inflammation, autoimmunity, toxic exposure, and so on). Although further considerations (such as degree of subjective distress and suffering on the part of the affected person) may play a role in determining whether particular therapeutic technologies should be deployed to arrest or reverse the dysfunction, neurobiology alone possesses sufficient internal resources to specify, in many cases, what a properly functioning neuron looks like because it can account for the role which neurons play (one is tempted to say, are supposed to play) within the physiology of the organism.

Even in states of affairs which conform to the conditions described here – myasthenia gravis, or multiple sclerosis, or barbiturate intoxication, for instance – the role of neurobiology in grounding clinical decision-making must not be overstated. Arguing that neurobiological method and knowledge can account for proper neuronal function in no way entails that this account is the primary motivator of medical-therapeutic intervention. It is of course possible that one would present to a physician because one has developed a proficiency in neurobiology and one suspects, based on this knowledge, that one’s neurons are not functioning properly. But this is surely not the primary or only driver of medical/therapeutic intervention. Most people who present as patients to medical clinicians for acute reasons (as opposed to health maintenance) do so because they are in distress, because their moral projects and goals are rendered (or threatened to be rendered) more difficult or impossible to attain, because they are in pain (or afraid that they will soon be in pain, or worse), because they are frustrated (or
They know that something must be wrong, but they do not necessarily know what is wrong. This request for help may originate from the patient (who, in requesting help within a medical context, thereby becomes the “patient”) and/or from others who are concerned about the patient; either way, it specifies the problem which the clinician, perhaps with the help of neurobiology, is tasked to solve. But neuronal dysfunction alone, absent distress/disability or fear of future distress/disability, may never present to medical attention; and if it does, it may not warrant therapeutic intervention. Dysfunction of a small peripheral sensory nerve may not even be noticed; dysfunction of an equivalent amount of neural tissue within the brainstem would often result in a massive medical/therapeutic response.

When one turns to the kinds of phenomena with which psychiatry deals, however, the limitations of neurobiology in grounding clinical practice become much more clear. Mental disorders – by which I mean, at this stage of the argument, “the conditions that motivate psychiatric care and therapeutic intervention,” without making any further ontological claims about them – can only rarely, at present, be described with reference only to the physiological function of the brain and nervous system (and when this is the case, as has often been pointed out, such conditions are henceforth considered disorders proper to other branches of medicine rather than psychiatry).  

Examine the brain and nervous system of a depressed person, without regard to behavioral context and subjective experience, and one will find a brain and nervous system which appears to be

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working as brains and nerves usually work – that is, until the body kills itself. Examine the brain of an opiate-dependent person, without regard to behavioral context and subjective experience, and one will find a brain in some stage of opioid-receptor saturation or withdrawal, but one will not thereby be able to determine whether the person is abusing opioids or taking them appropriately in collaboration with a physician for treatment of pain.

What is needed to make judgments about the presence of psychiatric disorders is a larger and wider frame of reference than the brain and nervous system per se. In psychiatric clinical work, one needs less an understanding of how brains and neurons typically function (though this knowledge is often valuable and occasionally indispensable) than of how persons typically function, or should be able to function, or are supposed to function, in various social/environmental contexts. Given the present state of neurobiology, one cannot judge whether or not a patient is “psychotic” by reference to the brain alone; one must also judge the appropriateness of the person’s behavior and self-reported experience within the larger context of his or her environmental “reality.”8 Similarly, one cannot at present judge whether someone is “manic” by looking at the brain alone; one must, at present, both engage the subjective account of the person and judge whether the person’s experience and behavior is appropriate to his or her social and environmental context. It is this personal distress and/or disconnect between personal behavior and experience and environmental/social

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8 Psychosis names a symptom within modern psychiatry, not a diagnosis, and is itself an elusive and nonspecific term which needs, and has received, substantial philosophical treatment in order to stand as a coherent concept (cf. George Graham, The Disordered Mind: An Introduction to the Philosophy of Mind and Mental Illness [London: Routledge, 2009]). I will not enter into that here.
context that in practice specifies a particular state of affairs as a “mental disorder.” Once this is specified, neurobiological method can then be employed to determine what, if anything, is occurring in the brain, nervous system, and other bodily systems to account for the disorder-labeled phenomena. But this is very different from claiming that neurobiology alone is sufficient for specifying what “mental disorder” is, or that neurobiology alone can ground clinical decision-making.

Recent years have witnessed a chorus of calls within the psychiatric and neuroscientific literature for a reform in psychiatric diagnostic classification to reflect contemporary findings in neurobiology. Although there is much to be valued in these proposals, it is important to note that none claim to propose a reductionistic neurobiological account of mental disorder. Rather, they argue that psychiatric nosologists, having identified a certain state of affairs as mental disorder, can and should turn to neurobiology for the investigation of potential causes and should model diagnostic classification in a way which responds to neurobiological data and which facilitates the search for further results. If, for example, large-scale genotyping of individuals manifesting the clinical syndrome of schizophrenia were to reveal two dozen distinct and apparently unrelated genetic patterns relative to non-affected persons, psychiatric diagnostic classification systems should perhaps adopt a “splitting” rather than a “lumping” approach and consider these as distinct neuropsychiatric disorders. But that

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“schizophrenia” describes disorder to begin with must be determined on grounds which precede any investigation of the genotype.10

Could a neurobiology of the future supply the functional concepts necessary to make judgments about whether particular brain states constitute psychiatric disorder? In the future, that is, could brain function as a whole be amenable to neurobiological analysis in the same way that local neuronal function is at present? This is clearly an expectation both of those who believe that neurobiology will eventually “explain away” higher levels of analysis11 and of those, including some theological thinkers, who believe that it will not.12 To these questions, we must say: perhaps. Setting a priori boundaries for the fruitful reach of scientific inquiry is historically a dangerous enterprise, and the lack of any currently available model for such a context does not mean that one will not be available in the future. But this must be qualified in two ways. First, a comprehensive neurobiological account of human mental function, human behavior, and sociality is nothing more than a conceptual possibility at present; it does not reflect neurobiology in its present form. Second, such a neurobiology would hardly be recognizable as “neurobiology.” As is already evidenced by the emergent fields of “cognitive neuroscience” and “social neuroscience,” when neuroscientists expand their scope of inquiry to the “higher” human functions of volition, cognition, emotional regulation, and social interaction, their work begins to look less and less like traditional neurobiology and more like psychology, sociology, economics, linguistics and philosophy. A neurobiology

capable of accounting for proper human function would of necessity borrow from and incorporate these disciplines, more and more to resemble a comprehensive “master science;” but in doing so, it would lose many of the characteristics which (misleadingly, in my judgment) attract many to modern neurobiology (and, in particular, biological psychiatry) in the first place: its perceived “objectivity,” its place in the realm of “fact” rather than the realm of “value,” its perceived ability to abjure from moral and political controversy. As the histories of psychiatry and psychology (not to mention sociology and economics) make clear, the application of reductive scientific methods to questions of political and moral consequence reliably provokes critique by those who would argue that such enterprises are not, in fact, “science” because they appear to be intruding into the politically contested realm of “value.” That this is a misunderstanding of science, as I will indirectly argue in the next chapter, is beyond the point: I wish here only to argue that a neurobiology capable of providing an account of proper human brain function sufficient to ground judgments about the existence of “mental disorder” would, most likely, not look much like modern neurobiology at all.

We will turn later in this chapter to sophisticated contemporary efforts to ground the concept of “mental disorder” through the use of biological methods, specifically Christopher Boorse’s model of disease as deviation from species-typical function and Jerome Wakefield’s model of dysfunction as a failure of a system to function as it was designed to do in evolution. But since neither of these theories – valid or not – are grounded in analysis of the brain and nervous system per se, we may venture an interim conclusion: because no satisfactory neurobiological account of “mental disorder” has yet
been proposed, the practice of modern clinical psychiatry is not and cannot at this time be comprehensively grounded in neurobiology. Although neurobiology can (and will continue to) provide information about the mechanism of disease processes, about neurobiological etiologies of particular disease symptoms, and about neurophysiologic and neuroanatomic correlates to behavior and experience, neurobiology cannot itself account for what does, and does not, constitute “mental disorder.” For that, one needs (possibly unnamed) concepts of disorder and disease which, however responsive to neurobiology, are not themselves derived from it.

2.2 The DSM and Its Critics: A Brief History of Psychiatric Diagnostic Classification

2.2.1 Psychiatric Nosology Before DSM-I

If, as I have argued, the practice of clinical psychiatry, including biological psychiatry, cannot at present be grounded in neurobiology alone but must rely on concepts of disease, illness, and/or disorder which are not themselves derived from neurobiology, it is clearly important to understand the social/historical context of psychiatric diagnosis as it has developed in Europe and North America (and, from there, the world\textsuperscript{13}) over the past century. Even a brief overview of this history will reveal that modern psychiatric diagnosis, however informed by scientific method, remains a highly contested practice for reasons not reducible to science. Although a comprehensive historical review of psychiatric nomenclature and a comprehensive review of modern psychiatric nosology are beyond the scope of this chapter, a brief overview will be offered.

work in the philosophy of psychiatry is well beyond the scope of this chapter and of this work as a whole, I will briefly review both here, with specific attention paid to those thinkers whose work is most relevant to the project of this dissertation.

It is clear that in the history of modern psychiatry, the identification of particular states of affairs as “mental illness” or “mental disorder” has not been a deductive exercise. Neither in the past nor in the present, that is, have leaders in the field agreed upon a clear conception of “mental disorder” and then, deductively, designed a diagnostic classification based solely on that conception. Historically, rather, diagnostic classifications came first, and sustained abstract philosophical/clinical reflection on the nature of “mental disorder” arose only when psychiatric practice was put to the question by various internal and external critics. Even now, psychiatric practice could go on (rightly or wrongly) with little difficulty if the currently regnant definitions of “mental disorder” were to be discarded, ignored, or forgotten, just as physicians and patients in non-psychiatric medical settings can go on despite the fact that very few could formulate a philosophically defensible description of “disease,” much less “health.” Philosophical reflection on “mental disorder,” then, has emerged not because it is necessary for practice but because thinkers internal and external to psychiatric practice have believed it necessary to defend psychiatry against critics and, as we will see, to prevent internal abuses of the medical model within psychiatry.

Although the identification and classification of what are now referred to as mental disorders is an ancient project, recognizable in some form even in Greek and
Roman medicine,\textsuperscript{14} the psychiatric classification systems dominant within modern biologically-oriented psychiatry (that of the \textit{Diagnostic and Statistical Manual of Mental Disorders [DSM]} and the closely related \textit{International Classification of Diseases and Related Health Conditions [ICD]}) trace their primary roots to the care of patients in the asylum as that institution rose to prominence in nineteenth-century Europe and North America.\textsuperscript{15} Just as Roy Porter argues that the practice of modern psychiatry emerged as a distinct clinical discipline due to the exigencies of caring for patients in the asylum and not \textit{vice-versa},\textsuperscript{16} so also the need to develop systems for the care and treatment of asylum patients gave rise to early psychiatric nosological reflection. Shorter refers to this nineteenth-century nosological project as the “first biological psychiatry,” to be distinguished from twentieth-century developments in pharmacology and technology. Though influential work was done by German scholars such as Wilhelm Griesinger, Theodor Meynert, Paul Flechsig, Carl Wernicke, Karl Kahlbaum and by the French scientists Philippe Pinel and Benedict-Auguste Morel (infamous for his “degeneration” hypothesis of schizophrenia, which held that insanity resulted from degeneration of family lines as acquired vice was transmitted to future generations), the most influential asylum psychiatrist, from the standpoint of twentieth-century nosology, was the German psychiatrist Emil Kraepelin. Unlike many of his colleagues and predecessors, and following the early example of Kahlbaum, Kraepelin attempted to ground classifications

\textsuperscript{14} The Hippocratic treatise \textit{On the Sacred Disease} largely argues against religious theories for epilepsy in favor of physiological ones. For examples of works which engage pre-modern nosologic systems, see Jennifer Radden, ed., \textit{The Nature of Melancholy: From Aristotle to Kristeva} (New York: Oxford University Press, 2002); Roy Porter, \textit{Madness: A Brief History} (Oxford Univ. Press, 2002).

\textsuperscript{15} Edward Shorter, \textit{A History of Psychiatry}, 33-68.

\textsuperscript{16} Porter, \textit{Madness}, 100.
of patients not on the basis of hypothesized lesions or diseases in the brain and nervous system, but rather by observing the clinical course of institutionalized patients and grouping them into categories based on observed symptoms and trajectory over time.

While never rejecting the premise that psychiatric illness is caused by biological brain lesions, Kraepelin’s methodology was nonetheless not dependent on the neurobiology of his day. His descriptive approach to psychopathology, which famously differentiated the syndromes of schizophrenia (dementia praecox) and manic-depressive illness for the first time, focused on lumping large groups of patients into common diagnostic categories, intentionally disregarding the specific details of patients’ life histories. Kraepelinian nosology prioritized the description of course and prognosis of illness over the description of cause, and in so doing foreshadowed the third (1980) and subsequent (1987, 1994, 2000) editions of the DSM. Kraepelin’s work was extended by descriptive psychopathologists such as Eugen Bleuler, who coined the term “schizophrenia,” and Kurt Schneider; in addition, Karl Jaspers’ 1911 General Psychopathology (Allgemeine Psychopathologie) shows a distinct Kraepelinian influence.

Kraepelin’s descriptive approach, while influential, was not uniformly embraced. Sigmund Freud, born the same year (1856) as Kraepelin, adopted a radically different approach to psychopathology through his work with middle- and upper-class Viennese outpatients (not asylum patients), focusing on less impaired individuals and emphasizing the generation of physical and emotional symptoms through unconscious conflict and the therapeutic efficacy of the “talking cure.” The psychoanalytic movement of which Freud

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was the founder both influenced certain of the descriptive psychiatrists (e.g., Bleuler) and
gave rise to a dizzying array of (mutually incompatible) theories of psychopathology with
their own classification systems.  

18 Although psychoanalysis, after nearly hegemonic control over American psychiatry in the mid-twentieth-century, has lost much of its influence within the culture and within the profession and is not the driving theoretical approach of the modern DSM, many psychoanalytic concepts and terms (e.g., borderline personality, narcissistic personality, conversion disorder) appear in DSM-IV. In addition, diagnostic classification continues to be heavily debated within contemporary psychoanalysis, 19 as evidenced by the 2006 publication of a diagnostic classification intended to rival the DSM 20.

Less influential in Europe but arguably more influential in the United States than either Kraepelin or Freud was Adolf Meyer, a Swiss-born psychiatrist who worked in the U.S. for nearly his entire career, most of that time at Johns Hopkins University. Meyer was both appreciative and critical of Kraepelin and Freud and borrowed ideas from each in constructing his own “psychobiological” view of mental illness, which admitted the possibility of biological predispositions to mental illness but portrayed mental disorder as “reaction types” to various social and psychological challenges. 21

2.2.2 DSM-I and DSM-II

Meyerian psychobiology was formative in the development of the first edition of the DSM, retrospectively referred to as DSM-I, in 1952.\textsuperscript{22,23} DSM-I was not the first diagnostic classification within American psychiatry, as a predecessor publication, the “Statistical Manual for the Use of Hospitals for the Insane,” had been published in several editions since 1918,\textsuperscript{24} and the New York Academy of Medicine, encouraged by the U.S. Bureau of the Census, had published a “Standard Classified Nomenclature of Diseases” since 1933. But these documents were used by – and useful only for – psychiatrists working in inpatient hospital settings among chronically institutionalized patients, focusing heavily on chronic conditions of presumed organic cause (neurosyphilis, for example). The rapidly changing role of psychiatry within American culture during and after the Second World War, however, prompted the development of a new classification system better suited for non-institutionalized patients. During the course of the war, the American military developed increased awareness of the high incidence rates of psychiatric casualties – soldiers incapacitated in the context of combat stress without evident physical wounds – and therefore became increasingly attentive to the role of psychiatrists in providing effective supportive care to those soldiers, many of whom quickly returned to the line of duty. This correlated, after the war, both with a dramatic shift of the scope of American psychiatry from inpatient to outpatient care.

\textsuperscript{22} Committee on Nomenclature and Statistics of the American Psychiatric Association, \textit{Diagnostic and Statistical Manual for Mental Disorders} (Washington, D.C.: American Psychiatric Association Mental Hospital Service, 1952); hereafter referred to as \textit{DSM-I}.
\textsuperscript{24} Grob, 426; of note, by the publication of \textit{DSM-I}, the name of this publication had been changed to “Statistical Manual for the Use of Hospitals for Mental Diseases.”
(whereas greater than two-thirds of American Psychiatric Association members were employed in hospitals in 1940, only 17% were employed in hospitals in 1956\textsuperscript{25}) and with an increasing need to care for combat veterans within the expanded bureaucracies of the military and Veterans Administration. Because the old classification systems were clearly inadequate – e.g., “relatively minor personality disturbances, which became of importance only in the military setting, had to be classified as ‘psychopathic personality’”\textsuperscript{26} – a new nosology, the *DSM*, was formed which divided mental disorders into “Disorders Caused By or Associated With Impairment of Brain Tissue Function” (e.g., “Acute Brain Syndrome associated with intracranial neoplasm”) and “Disorders of Psychogenic Origin or Without Clearly Defined Physical Cause or Structural Change in the Brain.” The former disorders are in our time nearly all considered the domain of neurology and infectious disease medicine; the latter, of psychiatry, including “biological psychiatry.” The latter category included subdivisions of “psychotic disorders” (manic depression, schizophrenia) and “psychoneurotic disorders” (anxiety, personality disorder); both psychotic and psychoneurotic disorders were phrased according to the Meyerian language of “reaction” (e.g., “schizophrenic reaction, hebephrenic type”). Each diagnostic category was described very briefly and nonspecifically, and the entire work was very small in relation to more recent editions of the *DSM*; *DSM-I* comprises only 130 pages. A closely related second edition of the *DSM*, referred to as *DSM-II*, was published in 1968 in order to employ less theoretically-laden disease labels (the Meyerian language of “reaction” was dropped) and to bring American nosology in conformity with

\textsuperscript{25} Ibid., 428.

\textsuperscript{26} George N. Raines, “Foreword” to *DSM-I*, vi-vii.
the simultaneously published *International Classification of Diseases, Eighth Revision (ICD-8).*

Notable in both *DSM-I* and *DSM-II*, in addition to their brevity, is the lack of any justification of the concept of “mental disorder” or of the application of “disorder” status to the phenomena (including homosexuality, albeit briefly and without comment) so labeled. Although the *DSM-II*, in particular, acknowledges that causation of disorder is disputed, the status of particular conditions as mental disorders falling within the domain of psychiatry is not. But all of that would soon change. By 1968, when the *DSM-II* was published, psychiatry was being publicly put to the question by internal and external critics, and criticism would soon extend to the *DSM* itself.

**2.2.3 Forcing the Question: Psychiatry and Its Accusers, 1960-1980**

One of the earliest (and still active, as of 2011) voices in what collectively has become known, perhaps too generally, as the “antipsychiatry” movement, was that of psychiatrist Thomas Szasz, whose libertarian philosophy of clinical practice (influenced by revulsion for the growing postwar totalitarianism in his native Hungary) first came to expression in *The Myth of Mental Illness: Foundations for a Theory of Personal Conduct* (1961, rev. ed. 1974). Unlike Michel Foucault, whose *Folie et Dérision: Histoire de la Folie a L’age Classique* (1961) offered a sweeping archaeological narrative of modern European marginalization of the “madman” through the asylum and then through less

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visible instruments of psychiatric power but did not focus either on contemporary psychiatric practice or contemporary psychiatric nosologies,\(^2^9\) Szasz centered his critique on the widespread postwar use of “mental illness” to describe what, in his view, were better described as problems of living. Szasz described “illness” in rigidly objectivist and biological terms, as “a bodily disorder whose typical manifestation was an alteration of bodily structure,” and complained that psychiatry “invented” mental illness by stretching the traditional concept of illness as “altered bodily structure” to mean “altered bodily function” demonstrated by behavior, even if no structural abnormality could be detected.\(^3^0\) Psychiatry, in Szasz’ judgment, was not properly a part of medicine, whose conceptual charge is “to study, and if necessary to alter, the physicochemical structure of the human body,”\(^3^1\) but should rather be considered akin to moral philosophy and ethics as “a theoretical science . . . consisting in the study of personal conduct.”\(^3^2\) Szasz describes this “invention” of mental illness in highly schematic form:

Under the old rules [of the Original Medical Game], illness was defined as a physicochemical disorder of the body which eventually manifested itself in the form of a disability. When disabled, the patient was to be protected and, if possible, treated for his illness; and he was usually excused from working and from other social obligations. On the other hand, when a person imitated being ill and disabled, he was considered and called a malingerer and was to be punished by physicians and social authorities alike. Under the new rules, the attitude toward this latter group – or at least toward many members of it – was redefined. Henceforth, persons disabled by phenomena that resembled bodily diseases but were in fact not such diseases– in particular so-called hysterics – were also classified as ill – that is, ‘mentally ill;’ and they were to be treated by the same rules that applied to persons who were bodily ill. I maintain, therefore, that Freud


\(^3^1\) Ibid., 4.

\(^3^2\) Ibid., 8.
did not discover that hysteria was a mental illness. He merely asserted and advocated that hysterics be declared ill.33

Szasz has produced a voluminous written corpus (hundreds of articles and dozens of books) in the nearly half-century since The Myth of Mental Illness first appeared. Though the specific content of his argument has varied over the course of his career, the themes are the same: the charge that psychiatry (and psychology and the other mental health disciplines) inappropriately assumes the medical model to describe conditions which are not valid medical disorders; that psychiatry uses this wrongly-appropriated medical model to justify various forms of coercion, especially including involuntary commitment; and that psychiatric technology, particularly medication, is but one form of this coercion.34

Joining Szasz and Foucault among the early critics of psychiatry was R. D. Laing, an icon of the 1960s counterculture whose most influential work, The Divided Self, also focused its critique on the identification of mental disorders. Laing opened his discussion in The Divided Self with an invective against the jargon so prevalent in the psychoanalysis of his day:

As a psychiatrist, I run into a major difficulty at the outset: how can I go straight to the patients if the psychiatric words at my disposal keep the patient at a distance from me? How can one demonstrate the general human relevance and significance of the patient’s condition if the words one has to use are specifically designed to isolate and circumscribe the meaning of the patient’s life to a particular clinical entity? Dissatisfaction with psychiatric and psycho-analytic words is fairly widespread, not least among those who most employ them. It is widely felt that these words of psychiatry and psycho-analysis somehow fail to

33 Ibid., 36-37.
express what one ‘really means.’ But it is a form of self-deception to suppose that one can say one thing and think another. . . the thought is the language, as Wittgenstein has put it.  

For Laing, psychiatric (and particularly psychoanalytic) jargon was a barrier, rather than an aid, in understanding patients since it distances patients from their experience and implies that the psychiatrist can faithfully narrate “what is going on” in abstraction without careful attention to the specificity of a patient’s self-narration of experience. Like the familiar image of the symmetrical lines which can be viewed either as faces or as a vase, but not both, the psychiatrist can view patients (and patients can view themselves) as “organisms” comprised of “it-processes” or as “person[s] seen . . as responsible, as capable of choice, . . as self-acting agent[s].”  

Relying heavily on existential theory, Laing therefore attempted to construct a theory of psychopathology which views the patient as “person” rather than as “thing.”

The first requirement of this “existential-phenomenological approach” related to psychotic patients is that the psychiatrist attend closely not only to the form (as in Kraepelin’s model) but also to the content of a patient’s mental experience. The content of a particular delusion or hallucination is as important as the recognition that a patient is delusional or hallucinating. Furthermore, if the psychiatrist applies a diagnostic category to a patient’s experience, the psychiatrist must be aware that “objectivity” in psychiatric diagnosis is impossible: “to see ‘signs’ of ‘disease’ is not to see neutrally.”

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36 Ibid., 18-21.

37 Ibid., 32.
if we look at [the patient’s] actions as ‘signs’ of a ‘disease,’ we are already
imposing our categories of thought on to the patient . . . it is just possible to have
a thorough knowledge of what has been discovered about the hereditary or
familial incidence of manic-depressive psychosis or schizophrenia, to have a
facility in recognizing schizoid ‘ego distortion’ and schizophrenic ego defects,
plus the various ‘disorders’ of thought, memory, perceptions, etc., to know, in
fact, just about everything that can be known about the psychopathology of
schizophrenia or of schizophrenia as a disease without being able to understand
one single schizophrenic. Such data are all ways of not understanding him. 38

Laing then asserted, pace the DSM-I, that “one cannot love a conglomeration of ‘signs of
schizophrenia.’ No one has schizophrenia, like having a cold. The patient has not ‘got’
schizophrenia. He is schizophrenic.” 39 And this determination, whether a patient is
“psychotic” or not, can only be made in a relationship. There is no objective way to
determine psychosis: “sanity or psychosis is tested by the degree of conjunction or
disjunction between two persons where the one is sane by common consent.” 40

Contemporaneous with the clinical writing of Szasz and Laing and the intellectual
archaeology of Foucault, a number of sociological thinkers, notably Erving Goffman 41
and the more polemical Thomas Scheff, 42 also published work which shed unfavorable
light on the organization of psychiatric care (Goffman) and argued that mental illness
itself was (only) social construction. 43 Although these early “antipsychiatry” writers
were known and debated among the reading public, it is difficult to document any
specific changes made within psychiatric practice as a whole which emerged as a direct

38 Ibid., 34.
39 Ibid., 35.
40 Ibid., 37.
41 Erving Goffman, Asylums: Essays on the Social Situations of Mental Patients and Other Inmates
   Transaction, 1999).
   and Mental Illness (Beverly Hills, Calif.: Sage Publications, 1982), 199-223.
effect of any of their critiques. Szasz was largely vilified and then ignored within the mainstream of American psychiatry, and his increasingly shrill rhetoric in the years and decades after the publication of *The Myth of Mental Illness* – comparing modern psychiatry to a caricatured version of the Inquisition, for instance\(^\text{44}\) -- seemed in the mind of many to justify this marginalization.\(^\text{45}\) Laing achieved celebrity as a countercultural icon, but his unorthodox clinical practices – experimenting with hallucinogens during therapy sessions, conducting “rebirthing” sessions with patients in therapy, serving a therapeutic community (Kingsley Hall) in which patients and psychiatrists lived communally with no distinction between them – also made him easy for orthodox psychiatrists to ignore. But other voices and events were much more salient for the American psychiatric establishment. The 1975 movie *One Flew Over the Cuckoo’s Nest*, based on a 1962 novel of the same name,\(^\text{46}\) depicted electroconvulsive therapy (ECT) and the psychiatric hospital, and by extension psychiatric practice – in a searingly negative light. Although the content of the film was widely derided as caricature by psychiatrists, its widespread dissemination among the American public increased public suspicion of psychiatry. In the scientific literature, a number of researchers began to question the validity of the diagnostic classifications of the *DSM-II*. In one study which proved particularly controversial within and embarrassing to the psychiatric establishment,\(^\text{47}\) a psychologist arranged for himself and seven other “pseudopatients” with no history of mental illness to present to a range of psychiatric hospitals (12 total) with complaint of

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\(^{46}\) Ken Kesey, *One Flew Over the Cuckoo’s Nest* (New York: Penguin Classics, 2002).

auditory hallucinations of a person of the same sex which, though difficult to decipher, sounded like “empty,” “hollow,” and “thud.” After admission they were instructed to act normally and to state that the symptoms had entirely disappeared. Although they began to seek discharge immediately upon admission, length of hospitalization ranged from 7 to 52 days (average 19 days) and all were discharged with diagnoses of schizophrenia or manic-depressive illness, most often specified to be “in remission;” many were treated with psychiatric medication while hospitalized.

Even more threatening to the psychiatric establishment, and damaging to the public credibility of psychiatric diagnosis, was the bruising debate over the presence of homosexuality as a form of mental illness in the *DSM*. Following mid-century psychoanalytic thought, which considered same-sex romantic attachment to be a deviation from normative heterosexual development, the architects of the *DSM-I* listed homosexuality, with little comment, under the category of “sexual deviation,” denoting “deviant sexuality which is not symptomatic of more extensive syndromes.”*DSM-II* likewise classified homosexuality as a sexual deviation and a “non-psychotic mental disorder.”*DSM-II* Because this pathological labeling was thought to perpetuate stigma against persons attracted to persons of their own sex, because it was often thought to legitimate painful and coercive “reparative” treatments of the time (e.g., delivering electrical shocks to individuals as they were exposed to homo-erotic imagery), and because it was not

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48 *DSM-I*, 38-39. Of note, the sexual deviations such as homosexuality, transvestitism, sexual sadism, and so on were considered under the broader category of “sociopathic personality disturbance” by which was meant only that “individuals to be placed in this category are ill primarily in terms of society and of conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals.”

49 *DSM-II*, 41-44.
reflective of contemporary psychological work, such as that of Evelyn Hooker, which demonstrated the existence of community-dwelling gays and lesbians who exhibited no other signs of distress or mental disorder and who appeared to be happy in same-sex relationships, the DSM and the American Psychiatric Association (APA) became increasing targets of protest by the emerging “gay liberation” movement. The details of this engagement have been extensively documented elsewhere, and need not be exhaustively recounted here.\textsuperscript{50} Briefly, however, visible and occasionally disruptive (though never violent) protests by gay activists at the annual APA conventions in 1970 and 1971 led to a decision in 1972 to sponsor a panel which included a personal account by a gay psychiatrist, John Fryer, who spoke (for fear, he stated, of reprisal) from an oversized mask under the name “Dr. H. Anonymous.”\textsuperscript{51} This led in the next year (1973) to a symposium at the APA annual convention in which gay activist Ronald Gold spoke alongside psychoanalytic proponents of homosexuality-as-diagnosis and, notably, to a vote by the APA Board of Trustees to remove homosexuality from the DSM-II and to replace it with a category titled “Sexual Orientation Disturbance,” which designated “individuals whose sexual interests are directed primarily toward people of the same sex and who are either disturbed by, in conflict with, or wish to change their sexual


orientation.” APA members opposed to this change forced a referendum in 1974 which, if successful, would have reinstated homosexuality in the diagnostic nomenclature, but the referendum failed by a 58%-37% margin, with 3% abstaining.

2.2.4 Psychiatric Diagnosis Clarified and Refined: Toward DSM-III and Beyond

Beleaguered by the antipsychiatry attacks, the negative scientific scrutiny discussed in the last section, and – especially – by the painful debates regarding the nosological status of homosexuality, American psychiatry was forced, beginning in the 1970s, to clarify its practice and to bring its working nosology, DSM-II, under more careful empirical scrutiny. Although a comprehensive history of psychiatry at this time is beyond the scope of this brief survey, a few scientific and philosophical initiatives stand out.

First, many prominent biologically-oriented psychiatrists, galvanized by Szasz’ attacks and skeptical of psychoanalysis and of politically active “social psychiatry,” began to advocate more publicly for a strict adherence to the medical model within psychiatry. This was particularly true of a fledgling group of researchers clustered within the psychiatry department of Washington University in St. Louis, who were influenced more by Kraepelin than by Freud and who sought to establish increasingly reliable (i.e., leading to increased agreement among clinicians) and valid (i.e., “cutting nature at its joints”) psychiatric diagnostic criteria. Eli Robins and Samuel Guze, two of

these researchers, argued famously, with reference to schizophrenia, that even in the absence of a clearly worked out pathophysiological model, psychiatric diagnoses could still be assessed according to several “validity criteria,” including clinical description, laboratory studies, delimitation from other disorders, follow-up study (prognosis), and patterns of shared illness in families.54 These same researchers, collaborating with others in the department, published in 1972 a set of diagnostic criteria (referred to as the “Feighner criteria,” for the first author of the paper) for 14 psychiatric disorders which was intended to increase inter-clinician reliability. These criteria were used in the development later in the decade of the so-called Research Diagnostic Criteria (RDC) by Robert Spitzer and colleagues at Columbia University, which served as an important forerunner to the dramatically revised third edition of the DSM, DSM-III, in 1980. These developments in psychiatric diagnostic classification, intended to provide psychiatry with a more reliable common language for diagnosis and treatment, were accompanied by a number of papers attempting to defend the medical model of psychiatry in the face of the antipsychiatry claims.55

Related but distinct from these “anti-antipsychiatry” efforts were a number of efforts in the 1970s to define criteria for mental illness (or mental disorder) as such, apart from specific diagnostic categories (such as schizophrenia). Closely related to, and influential within, work in the philosophy of medicine to refine philosophical

understanding of health and disease,\textsuperscript{56} this work was directed both to the Szaszian critique that “mental illness” was, as such, a category mistake, and in some cases to the belief, held by many psychiatrists after the debates of 1973 and 1974, that \textit{DSM-I} and \textit{DSM-II} had erred by pathologizing a condition (homosexuality) which was not in fact a disease or disorder. If psychiatry understood what sort of thing a “mental disorder” is, the logic went, then perhaps psychiatry can avoid similar embarrassing mistakes in the future (though the diagnostic status of homosexuality was, in the mid-1970s, still a very active subject of debate). I will briefly review three of the more influential proposals here: that of the British psychiatrist R. E. Kendell, the philosopher Christopher Boorse, and the American psychiatrist George Engel.

R. E. Kendell (1935-2002), a British psychiatrist who served both as a professor of psychiatry in Edinburgh and as Chief Medical Officer of Scotland, was best known for his contributions to the literature on psychiatric diagnostic validity and reliability. His theory of psychiatric disease concepts, however, most clearly put forth in an article\textsuperscript{57} and monograph\textsuperscript{58} published in 1975, has served as a reference point for further conceptual debate. Kendell begins his paper by acknowledging the existence of the antipsychiatry critiques and the vague and changing use of “disease” within medicine:

Most doctors never give a moment’s thought to the precise meaning of terms like illness and disease, nor do they need to. They simply treat the patients who consult them as best they can, diagnose individual diseases whenever they can,

and try to relieve their patients’ suffering even if they can’t. . . The practical nature of medicine is not conducive to theorizing. But there are some situations in which this unthinking empiricism is inadequate. Psychiatrists are only too well aware of this, since they are often required to express opinions about the presence or absence of illness in the courts, and to defend these opinions to hard-headed lawyers, but they have not been conspicuously successful in finding a solution.”

Kendell acknowledges the force of, but does not endorse, the commonly held assumption that “the answer [doctors] give to the question, ‘Is this a disease?’ is really a covert answer to the quite different question, ‘Should this person be under medical care?’”

Rather, he says, disease concepts have evolved in haphazard ways concurrent with new developments in medical science and practice, from ancient conceptions that (what are now called) signs and symptoms are themselves diseases (e.g. fever, rash), to Sydenham’s description of disease as “syndrome,” or constellation of related symptoms useful for defining prognosis, to the development of the “lesion” theory of disease successively defined by new discoveries in gross anatomy and histology (Morgagni, Bichat), cellular pathology (Virchow), and microbiology (Koch, Pasteur). Modern diagnostic nosology has retained concepts and labels from all of these movements (together with more recent ones), such that “the diseases we currently recognize are rather like the furniture in an old house, in which each generation has acquired a few new pieces of its own but has never disposed of those it inherited from its predecessors.”

Kendell dismisses as too broad “any definition of disease which boils down to ‘what people complain of,’ or ‘what doctors treat,’” noting that such concepts are “free to expand or contract with changes in social attitudes and therapeutic optimism and [are] at

59 Kendell, “The Concept of Disease and Its Implications for Psychiatry,” 306.
60 Ibid.
61 Ibid., 307.
the mercy of idiosyncratic decisions by doctors or patients.”  

He dismisses as too narrow, however, any theory of disease which (like that of Szasz) requires the presence of a definable physical lesion. In its place, building on Scadding’s prior notion of disease as “biological disadvantage,” he argues that “disease” is any condition which reduces fertility or shortens life, and that many “mental illnesses” are properly called diseases, even in the absence of known physical lesions, if and when they are associated with decreased fertility or early mortality. He notes that this conservative conception of disease clearly includes homosexuality – which, along with schizophrenia, is a primary example of a condition associated with decreased fertility – but excludes conditions which are associated with discomfort and suffering but not with mortality or reduced fertility. It also excludes from the category of “mental illness” many of the conditions “treated” by mid-century psychiatrists:

The attempt to relieve suffering is medicine’s oldest and noblest tradition, and I am not suggesting that psychiatrists should stop trying to help husbands and wives live together in harmony, or aimless adolescents to find their feet. But if we are to venture into such areas let it be in full recognition of the fact that in doing so we may be straying outside our proper boundary, and that in the end it may turn out that other people can deal with such problems as well as or better than we can, and that in these areas their training and their concepts are more appropriate than ours. By all means let us insist that schizophrenia is an illness and that we are better equipped to understand and treat it than anyone else. But let us not try to do the same for all the woes of mankind.

Joining Kendell in defending the disease model of psychiatry against the antipsychiatrists was Christopher Boorse. In a series of four papers which appeared between 1975 and 1977 Boorse articulated what he has later referred to as the

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62 Ibid.
64 Kendell, “The Concept of Disease and Its Implications for Psychiatry,” 314.
“biostatistical theory” of disease. Acknowledging that “normativism,” the range of views holding that norms of health “must be determined, in whole or in part, by acts of evaluation,” or that “all judgments of health include value judgments as part of their meaning,” was the dominant view among contemporary theorists of health, Boorse attempted to articulate an alternative “naturalism” which would provide a “value-free” theory of disease. Doing so, for Boorse, required looking beyond medical practice, which is necessarily evaluative, to medical theory, “a body of doctrine that describes the functioning of a healthy body, classifies various deviations from such functioning as diseases, predicts their behavior under various forms of treatment, etc.” Such theory, Boorse held, understands the organism as an integrated set of parts with particular natural functions, understood as standard causal contributions to goals actually pursued by the organism. This integrated set of part-functions can be understood as the organism’s biological design. The characteristic feature of “disease” is, then, interference with the natural function of one or more of the organism’s parts. Boorse’s theory relies on statistical normality as a criterion for the discernment of design:

1. The reference class is a natural class of organisms of uniform functional design; specifically, an age group of a sex of a species.

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67 Ibid., 56.

68 Ibid., 57; Boorse, “Wright on Functions.”
2. A normal function of a part or process within members of the reference class is a statistically typical contribution by it to their individual survival and reproduction.

3. Health in a member of the reference class is normal functional ability: the readiness of each internal part to perform all its normal functions on typical occasions with at least typical efficiency.

4. A disease is a type of internal state which impairs health, i.e. reduces one or more functional abilities below typical efficiency.69

A body may function according to design without the body being a particularly excellent body – Boorse gives the example of a 1965 Volkswagen which might be in “perfect mechanical condition” and yet still not a very good car – and so “health” is not “a state of complete physical, mental, and social well-being,” as in the oft-quoted World Health Organization formulation, but rather “functional normality.”70 Boorse understands mental health and psychopathology according to the standards of physiological medicine; there are “natural mental functions,” and “recognizable types of psychopathology are unnatural interferences with these functions.”71 Like Kendell, however, Boorse conceded that the antipsychiatry critiques correctly accused contemporary psychiatry of drawing the boundaries of pathology too broadly; “apart from a theory of the structure and functions of the human mind, virtually all assertions about mental health are either misuses of language or flatly conjectural.”72 In order to recognize mental disease correctly, that is, one must have a developed account of how the human mind functions.

69 Boorse, “Health as a Theoretical Concept,” 555.
70 Boorse, “On the Distinction Between Disease and Illness,” 60; also Boorse, “Health as a Theoretical Concept.”
71 Ibid., 62; also Boorse, “What a Theory of Mental Health Should Be.”
72 Boorse, “What a Theory of Mental Health Should Be,” 81.
Boorse suggests that psychoanalysis is, in this respect, the contemporary theory most likely to succeed in demarcating normal from abnormal mental function.

A third philosophical contribution to the theory of psychiatric disease appearing in the 1970s, notable for its wide influence on subsequent generations of clinicians, was psychiatrist George Engel’s “biopsychosocial model,” articulated in one influential paper appearing in *Science* in 1977. Unlike Boorse, who sharply differentiated disease (a value-free theoretical concept denoting disordered part-function) from illness (a value-laden practical concept denoting those diseases that are judged evaluatively to be serious and to convey their owners with right to special treatment and diminished moral accountability), Engel used the two terms nearly interchangeably and gave primacy to the experience of disease/illness, arguing that modern scientific biomedicine (and its theory) functions as a “folk model” to describe and explain the experience of illness. Engel decries both “reductionists” who would reduce all behavioral and experiential phenomena of disease to “physicochemical principles” and “exclusionists” who would exclude from the category of disease anything which cannot be so reduced, invoking Von Bertalanffy’s general systems theory to argue for a “biopsychosocial” model which accounts not only for physicochemical processes but also for “the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system.”

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75 Engel associates the latter position with Szasz and the former with biological psychiatrists of his day. But both positions describe Szasz perfectly well.
76 Engel, 132.
Engel, in other words, attempts to defuse the Szaszian critique by arguing that demonstrating biochemical dysfunction, in psychiatry or in medicine more broadly, is neither necessary nor sufficient for the determination of a particular state as “illness” or “disease.” Even in the absence of known biochemical lesion, “the doctor’s task is to account for the dysphoria and the dysfunction which lead individuals to seek medical help, adopt the sick role, and accept the status of patienthood.”77 Even the determination of “why some individuals experience as ‘illness’ conditions which others regard merely as ‘problems of living,’ be they emotional reactions to life circumstances or somatic symptoms” falls within the professional domain of the physician.78

All of these movements – the historical development of psychiatric diagnosis as encoded in *DSM-I* and *DSM-II*, the subsequent sociocultural criticisms of psychiatry, the theoretical defenses of the disease concept in the light of these criticisms, the debate over the diagnostic status of homosexuality, the rising prominence of biological psychiatry, and the Washington University-led movement to increase reliability in psychiatric diagnosis – served as background and source for the significantly revised third edition of the *DSM*, the *DSM-III*, in 1980. In preparation from 1974 to 1979, the document continued certain key diagnostic constructs such as depression (renamed “major depression”), manic-depressive illness (renamed “bipolar disorder”) and schizophrenia, but in other ways scarcely resembled *DSM-II*. Chaired by psychiatrist Robert Spitzer of Columbia University, the American Psychiatric Association workgroup tasked with the revision of the manual – the DSM-III Task Force – developed a set of detailed criteria for

77 Ibid., 133.
78 Ibid.
each proposed diagnosis which focused on reported symptoms and observable signs and which were supposedly, in the intention of the task force, “atheoretical with regard to etiology or pathophysiological process except for those disorders for which this is well established and therefore included in the definition of the disorder.” 79 Designed to be useful to clinicians of varying theoretical orientation and to increase interclinician diagnostic reliability, these criteria sets were then tested in field trials in which, among other things, the usefulness and reliability of these categories was measured. In a nod to the biopsychosocial model, DSM-III introduced a multiaxial diagnostic system in which psychiatric diagnosis was to occur along five “axes” listing mental disorders (in Axis I and Axis II), physical disorders and conditions (Axis III), severity of psychosocial stressors (Axis IV), and highest level of adaptive functioning in the past year (Axis V). 80 And, notably, DSM-III included for the first time a general description of “mental disorder.”

In an essay written during the DSM-III preparation period by two architects of the document, Spitzer and Endicott (1978) state that the debate over homosexuality led them to believe that a profession-wide consensus on the nature of mental disorder was necessary because, in part, “without some definition of mental disorder, there would be no explicit guiding principles that would help to determine which conditions should be included in the [diagnostic] nomenclature, which excluded, and how conditions included

80 Ibid., 8.
should be defined."^{81} After an initial proposed definition met an icy reception at the 1976 APA annual meeting, they argued for a revised definition which would “[help to] delineate the areas of responsibility of the medical system from those of other societal systems which also have as their purpose improving or otherwise changing human functioning,” would “[provide] a rationale for decisions as to which conditions should be included or excluded from a medical classification,” and would “[provide] guidelines for determining the boundaries of those disorders which are seemingly continuous with variations in ‘normal’ functioning.”^{82} Situating “mental disorder” within the broader category of “medical disorder,” they argue that a medical disorder is characterized by (1) negative consequences, (2) an inferred or identified organismic dysfunction, and (3) an implicit call for action to the medical profession and to society.^{83} Mental disorder was then defined as “a medical disorder whose manifestations are primarily signs or symptoms of a psychological (behavioral) nature, or if physical, can be understood only using psychological concepts.”^{84} More specifically, a condition is a medical disorder if in the fully developed or extreme form, in all environments (other than one especially created to compensate for the condition, [it] is directly associated with distress (acknowledged by the individual or manifested), disability (some impairment in functioning in a wide range of activities), or disadvantage.^{85}

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82 Ibid., 17.
83 Ibid., 17-18. Of note, the prospect that psychiatrists would state that mental disorders were a subclass of medical disorders prompted strong reactions from psychologists, and for this reason the DSM-III does not engage the relationship of mental to medical disorders; see Robert L. Spitzer and Janet B. W. Williams, “The Definition and Diagnosis of Mental Disorder,” in Walter R. Gove, ed. Deviance and Mental Illness (Beverly Hills, Calif.: Sage Publications, 1982), 15-32.
84 Ibid., 18.
85 Ibid.,
Examples of “disadvantage” include “impaired ability to make important environmental discriminations,” “lack of ability to reproduce,” “cosmetically unattractive because of a deviation in kind, rather than degree, from physical structure,” and “impairment in the ability to experience sexual pleasure in an interpersonal context.”\(^{86}\) Acknowledging that the description of disadvantage as medical disorder is heavily dependent on social evaluation and will therefore be controversial, they nonetheless argue that in specific situations, disadvantage even in the absence of distress or disability is widely understood to be a sign of “organismic dysfunction” and therefore an appropriate target for medical intervention. In addition, they write, the controlling variables of the disorder need to be within the organism, the condition must not be quickly reversible by simple education or nontechnical interventions, the distress/disability/disadvantage cannot be the necessary price associated with attaining some positive goal, and the disorder must be able to be distinguished from other disorders.\(^{87}\)

The definition of mental disorder which appeared in *DSM-III*, fashioned by Spitzer and his wife Janet Williams in response to ongoing feedback and criticism, dropped the “disadvantage” criterion in favor of “dysfunction” and clarified that “mental disorder” could not be used solely as a way to describe social deviance. Although, as *DSM-III* states, there is “no satisfactory definition that specifies precise boundaries for the concept ‘mental disorder,’”\(^{88}\)

In *DSM-III* each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an

\(^{86}\) Ibid.

\(^{87}\) Ibid., 26-29.

\(^{88}\) *DSM-III*, 5.
individual and that is typically associated with either a painful symptom (distress) or impairment in one or more areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society.\textsuperscript{89}

The document also clarifies that a classification of mental disorders does not classify individuals but rather “disorders that individuals have,” such that terms like “a schizophrenic” and “an alcoholic” are avoided in favor of “an individual with Schizophrenia” and “an individual with Alcohol Dependence.”\textsuperscript{90}

The \textit{DSM-III} definition of mental disorder has proved broadly influential within the subsequent editions of the \textit{DSM}, despite much criticism. The \textit{DSM-III} definition stayed largely intact in the \textit{DSM-III-R} (Third Edition-Revised), published in 1987, with the exception that “a significantly increased risk of suffering death, pain, disability, or an important loss of freedom” was added to distress and disability as distinguishing conditions of “disorder” and that, furthermore, the syndrome or pattern “must not be merely an expectable response to particular event, e.g., the death of a loved one.”\textsuperscript{91} The definition was carried forward largely unchanged in \textit{DSM-IV}, published in 1994.\textsuperscript{92}

Although the fifth edition of the \textit{DSM} (\textit{DSM-5}\textsuperscript{93}) is still in development and has not yet been published, the definition of mental disorder proposed for this document carries

\textsuperscript{89} Ibid., 6.
\textsuperscript{90} Ibid.
\textsuperscript{91} American Psychiatric Association, \textit{Diagnostic and Statistical Manual of Mental Disorders}. 3\textsuperscript{rd} ed. – revised. (Washington, D.C.: American Psychiatric Association, 1987), xxii. This document is hereafter referred to as \textit{DSM-III-R}.
\textsuperscript{92} American Psychiatric Association, \textit{Diagnostic and Statistical Manual of Mental Disorders}. 4\textsuperscript{th} ed. (Washington, D.C.: American Psychiatric Association, 1994), xxi-xxii. This document is hereafter referred to as \textit{DSM-IV}.
\textsuperscript{93} The framers of the forthcoming fifth edition of the \textit{DSM} have begun to denote the edition number with an Arabic rather than Roman numeral, so I will follow the same convention here.
forward the key clauses of the *DSM-IV* definition, with the interesting addition of a clause stating that changes to the diagnostic nomenclature should be subjected to a harm/benefit calculus.94

2.2.5 Critics of Psychiatry After DSM-III

*DSM-III* was widely heralded by its psychiatric proponents as a triumph of “scientific psychiatry” which reinforced the status of psychiatry as a branch of medicine, which restored reliability to psychiatric diagnosis, and which rendered diagnosis more amenable to scientific critique and scrutiny. Whether or not these claims are justified, it is clear that criticisms of psychiatry have continued unabated after 1980. These critiques

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94 The full proposed *DSM-5* definition of mental disorder is as follows (from [http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=465](http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=465) [accessed March 18, 2011]):

A. A behavioral or psychological syndrome or pattern that occurs in an individual
B. The consequences of which are clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning)
C. Must not be merely an expectable response to common stressors and losses (for example, the loss of a loved one) or a culturally sanctioned response to a particular event (for example, trance states in religious rituals)
D. That reflects an underlying psychobiological dysfunction
E. That is not primarily a result of social deviance or conflicts with society
F. That has diagnostic validity on the basis of various diagnostic validators (e.g., prognostic significance, psychobiological disruption, response to treatment)
G. That has clinical utility (for example, contributes to better conceptualization of diagnoses, or to better assessment and treatment)
H. No definition perfectly specifies precise boundaries for the concept of either “medical disorder” or “mental/psychiatric disorder”
I. Diagnostic validators and clinical utility should help differentiate a disorder from diagnostic “nearest neighbors”
J. When considering whether to add a mental/psychiatric condition to the nomenclature, or delete a mental/psychiatric condition from the nomenclature, potential benefits (for example, provide better patient care, stimulate new research) should outweigh potential harms (for example, hurt particular individuals, be subject to misuse).

See also D. J. Stein and others, “What is a Mental/Psychiatric Disorder? From DSM-IV to DSM-V,” *Psychological Medicine* 2010 (40): 759-765.
are extraordinarily diverse in scope, and space will permit only a sampling of the most influential voices here.

The psychiatric professional milieu in which DSM-III appeared was different in many ways from the European and American psychiatry of the 1950s and 1960s which spawned the first generation of antipsychiatry critiques. Psychoanalysis had by 1980 lost its hegemony over American academic departments of psychiatry; psychiatric inpatient lengths-of-stay had decreased dramatically, as well as the size of public mental hospitals, as a result of the “deinstitutionalization” movement; psychiatrists were increasingly focusing attention on prescription of medication rather than on long-term psychotherapy, which was increasingly the province of psychologists, social workers, and other non-physician clinicians. The activist “social psychiatry” movement had been marginalized within the psychiatric guild by more biologically oriented psychiatrists. Although many of the first generation of critics (particularly Thomas Szasz) continued to offer many of the same arguments as before, criticisms of psychiatry since 1980 have, on the whole, reflected these large-scale cultural and professional changes. I will limit my survey here to an engagement with those who have focused their criticisms on the DSM itself. Although critiques of the DSM after 1980 (hereafter referred to as the “modern DSM”) have taken many forms, in many different formats, I will survey four influential themes here: that the modern DSM purports to be “scientific” (understood in a positivist sense) when it is fact the product of particular, contingent politics; that the modern DSM project has failed to uphold the interests of women; that the DSM treats most mental disorders as

universal human possibilities when some are, in fact, manifest only within particular
cultural contexts; and that the DSM serves as a tool for pathologizing normal human
experience.

Criticism 1. The self-description of the modern DSM as a triumph of scientific
rationality serves as a rhetorical tool to obscure its intrinsically political nature.

Although the empiricist claims of the modern DSM had met with early challenge,⁹⁶ social
workers Herb Kutchins and Stuart A. Kirk, in two books and other articles, have issued
the most sustained critique of the modern DSM on the grounds that it inappropriately
minimizes its intrinsically political nature in the name of scientific objectivity.⁹⁷ In The
Selling of DSM, they question the success of the DSM-III revision process in solving the
problem of diagnostic reliability, which had served as the cornerstone of the DSM-III
Task Force’s argument for the need for a revision of DSM-II. The DSM-III creators,
particularly Robert Spitzer, argued repeatedly that the nebulous phrasing and unreliable
application of the DSM-II criteria put the credibility of psychiatric diagnosis, and
therefore of psychiatry, at risk. Kutchins and Kirk argue that in introducing a statistical
measure of interclinician agreement, the kappa statistic, into the literature on psychiatric
diagnosis, Spitzer and colleagues transformed this purported classification problem into a
“technical problem” demanding solution from technical experts.⁹⁸ The DSM-III Task
Force repeatedly used the rhetoric of reliability to sell the DSM-III revision effort to

⁹⁶ For example, see David Faust and Richard A. Miner, “The Empiricist and His New Clothes: DSM-III in
⁹⁷ Stuart A. Kirk and Herb Kutchins, The Selling of DSM: The Rhetoric of Science in Psychiatry (New
York: Aldine de Gruyter, 1992); Herb Kutchins and Stuart A. Kirk, Making Us Crazy: DSM: The
Psychiatric Bible and the Creation of Mental Disorders (New York: Free Press, 1997).
skeptical constituents within and without the American Psychiatric Association. Kirk and Kutchins argue, however, that the highly-touted *DSM-III* field trials, supposedly the empirical verification of the superior reliability of *DSM-III*, were marred by methodological bias, by incomplete and sometimes contradictory reporting of results, by arbitrary standards for using and interpreting the kappa statistic, and by the fact that in published results of the trials, the kappa coefficients for most of the measured diagnostic criteria was below the level \( k = 0.70 \) pre-specified to describe “good” reliability.\(^9^9\) In addition, they argue that there is no reason to believe that the reliability of diagnosis measured in (more or less) tightly controlled research protocols will translate to the less structured world of actual clinical practice, where clinicians who are not researchers or experts routinely assign *DSM* diagnoses in the absence of structured research interviews. But none of this uncertainty was communicated by the DSM-III Task Force, which used the promise of enhanced reliability as a central pillar of a determined campaign of rhetorical persuasion. Kirk and Kutchins argue that the claims of *DSM-III* proponents to have launched a scientific revolution within psychiatry are exaggerated – more “rhetoric” than substance – and serve to conceal what they charge is a more insidious function of the modern *DSM*: to expand the professional territory of psychiatry, to marginalize nonmedical mental health providers, and to extend the boundaries of psychopathology to more and more states of affairs which would previously have been understood in non-medical terms. In *Making Us Crazy*, a second book written for a more broadly popular audience, they expand on these themes, providing extended historical narrations of

\(^{99}\) Ibid., 143-148.
various diagnostic controversies (e.g., the debate over homosexuality, the ratification of post-traumatic stress disorder, and the controversy [referenced below] over ‘masochistic’ and ‘self-defeating’ personality disorder) in order to argue that the modern DSM has led to the “increasing ‘pathologizing’ of everyday behavior,” displays “the fragility of science in the face of political advocacy,” and “can be an instrument that pathologizes those in our society who are undesirable and powerless, . . . not because of any malicious intent but because of unspoken cultural biases about what should be considered normal and what should be considered disease.”

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Criticism 2. The modern DSM is biased against the interests of women, particularly with regard to issues of sexual trauma. The DSM-III was created in part to save psychiatry from further damaging controversies like the debate about the status of homosexuality in the 1970s, but the 1980s nonetheless brought concerted protest from feminist clinicians which in some ways resembled the concerns of gay activists in the previous decade. The point of criticism was the proposal in the early 1980s, after the publication of DSM-III, that “masochistic personality disorder” (MPD) be included in the forthcoming revision to be known as DSM-III-R. An initial draft of the criteria for MPD required “feelings of martyrdom and self-defeating behavior as indicated by at least six of the following,” followed by nine possible descriptions including “remains in relationships in which others exploit, abuse, or take advantage of him or her, despite opportunities to alter the situation,” “believes that he or she almost always sacrifices own interests for

100 Kutchins and Kirk, Making Us Crazy, 16.
those of others,” and “sabotages his or her own intended goals.” This proposal, generated by a committee dominated by white men, incurred the ire of feminist observers, particularly Paula Caplan, a psychologist who had just published an essay entitled “The Myth of Women’s Masochism.” Caplan and others believed that MPD erroneously implied that individuals in abusive relationships enjoy suffering and that it could be used to pathologize as “mentally disordered” women who remained in some form of abusive relationship. Despite this protest, however, the diagnosis progressed through multiple revisions for inclusion in the *DSM-III-R*, only to be blocked as a fully-included diagnosis at the last minute by the APA Board of Trustees. The *DSM-III-R* included MPD in revised and somewhat attenuated form (along with “late luteal phase dysphoric disorder” and “sadistic personality disorder”) in an appendix of “proposed diagnostic categories needing further study” as “self-defeating personality disorder (SDPD).” Ongoing protest from feminists and others resulted in the diagnosis being dropped completely from *DSM-IV*, though another controversial category, “late luteal phase dysphoric disorder,” was adopted in *DSM-IV* as “premenstrual dysphoric disorder” and has hence become a commonplace diagnostic category. Before it was clear that MPD/SDPD would be dropped from *DSM-IV*, however, Caplan and her colleagues proposed a new disorder for consideration entitled “Delusional Dominating Personality Disorder (DDPD)” which required six of 14 criteria, including for example “excessive need to inflate the importance and achievements of oneself, males in general, or both. . .,” “a pronounced tendency to categorize spheres of functioning and sets of behavior rigidly

101 Ibid., 132.
according to sex, e.g. believe that housework is women’s work,” and “a tendency to feel inordinately threatened by women who fail to disguise their intelligence.” When the DSM-IV Task Force (and its chair, Allen Frances) accorded the proposal an icy reception, Caplan resigned her position as a consultant to the DSM revision process and eventually published a book criticizing the DSM as male-dominated and politically motivated.104

Criticism 3. The modern DSM treats most mental disorders as universal human possibilities when some are, in fact, manifest only within particular cultural contexts. With the publication of DSM-III, the DSM was increasingly used in non-North American cultural contexts. Although neither DSM-III nor DSM-III-R directly address cultural variation in expression of psychopathology, DSM-IV did include a prefatory statement on “ethnic and cultural considerations” acknowledging that cross-cultural diagnosis is perilous and acknowledging “wide cultural variation in concepts of self, styles of communication, and coping mechanisms.”105 The DSM-IV authors attempted to address these concerns by providing some information on possible cultural variation within the diagnostic categories and, notably, by including an appendix of “culture-bound syndromes,” defined as

recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. . . Culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations.106

105 DSM-IV, xxiv-xxv.
106 Ibid., 844.
Examples include *ataque de nervios* among Latin Americans, *amok* in southeast Asian cultures, and rootwork among residents of the southern United States. The principal criticism of this approach, however, is that it fails to name the possibility that some of the standard *DSM* criteria (the most often cited example is anorexia nervosa) are culture-bound as well, albeit within the educated, white, North American culture which produced the *DSM*. Ethan Watters has recently expanded on this criticism by alleging that some *DSM* categories have been exported, often through relief work and/or pharmaceutical marketing, into non-western cultural contexts and have changed the way in which individuals in those cultures understand psychopathology.

Criticism 4. *The DSM pathologizes normal human experience.* A common charge against the modern *DSM* is that it serves as an agent of medicalization, rendering “pathological” experiences and behaviors which would not otherwise be considered proper domains of the medical model. Often, but not always, these critiques have also been critiques of the pharmaceutical industry, often accused of selling diagnoses in order to sell psychiatric drugs. In one variant of this general critique, using a model of mental disorder which will be explored further in the next section, Allan Horwitz and Jerome Wakefield charge that by ignoring the traditional distinction between

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“endogenous” and “reactive” depression, or between “melancholia” and normal sadness in its description of major depression, *DSM-III* and its successors provided no internal resources for clinicians to avoid the medicalization of normal sadness. This is problematic, they argue, not only because of the likelihood that “normal sadness” will be seen as an appropriate target of medication, but also because it becomes impossible not to overestimate the prevalence of non-reactive major depression in the population.110

2.3 What Is a Mental Disorder? Contemporary Philosophical and Clinical Debates

Just as the modern *DSM* project beginning with *DSM-III* did not put an end to criticisms of the *DSM* or of psychiatry (quite the opposite, in fact), neither did it curb creative philosophical work around the concept of “mental disorder.” The years since 1980, in fact, have seen a minor proliferation in scholarly work, particularly within philosophy, on subjects related to psychiatric nosology and the nature of “mental disorder.” This movement, sometimes referred to as “philosophical psychopathology” or, more descriptively, as “philosophy of psychiatry,” has gained some degree of organizational coherence with the formation of academic organizations (the Association for the Advancement of Philosophy and Psychiatry in the United States and the International Network for Philosophy and Psychiatry in Europe), the sponsorship of an academic journal (*Philosophy, Psychiatry, and Psychology*), and an edited book series through Oxford University Press. (Unfortunately, as will be discussed in the next chapter, it has had little recognizable influence so far on the practical work of the crafters

of the forthcoming edition of the DSM [DSM-5] or on psychiatric policy-makers.) As the modern philosophy-of-psychiatry literature is rapidly proliferating and cannot be exhaustively reviewed here, I will focus here on key contemporary proposals on the nature of “mental disorder” which will help to frame the constructive arguments of the following two chapters of this work. Although the thinkers I will survey here are too complex and internally diverse to fit neatly into a conceptual taxonomy, I will nonetheless describe three broad approaches. First, I will focus on contemporary thinkers, particularly Jerome Wakefield (as well as Christopher Boorse, already detailed), who continue to hold to some version of a “naturalistic” (ostensibly value-free, at least in part) account of disease or disorder. Second, I will focus on several thinkers, particularly K.W.M. Fulford and John Sadler, who hold on the contrary that ascription of mental disorder is irreducibly and inextricably evaluative. Third, I very briefly detail a number of other contemporary theorists of mental disorder – Derek Bolton, Peter Zachar, S. Nassir Ghaemi, and David Brendel – whose views are diverse but who can broadly be classified as advocating a pragmatic approach to the ascription of “mental disorder.” These theories form one essential context for evaluation of my own Thomistic account of “mental disorder” offered in Part Two of this work.

2.3.1 “Naturalistic” Accounts of Mental Disorder

Perhaps the most active point of debate regarding the philosophical status of “mental disorder” has been whether “disorder” is an evaluative or a value-free concept, which in turn, of course, demands assent to the existence of some sort of fact-value
distinction and, more broadly, to the existence of “values.” At stake, supposedly, is the degree to which psychiatric nosology, and by extension psychiatry as a clinical practice, can claim an objective scientific foundation (to use three interrelated but disputed terms) independent of the interests of those who engage in the practice. This debate over the value-implications of psychiatric practice derives partly from debates within analytic philosophy about the relationship of description to evaluation, partly from debates about concepts and health and disease within the philosophy of medicine, and partly from longstanding debates, referenced above, between critics and defenders of the medical model of psychiatry.

Although debates about whether “health” and “disease” are inextricably evaluative have appeared within the broader philosophy-of-medicine literature (not primarily concerned with psychiatry),\(^\text{111}\) naturalistic defenses of “mental disorder” within psychiatry arose largely in response to the sociocultural antipsychiatry critiques. Although the earliest wave of such defenses was articulated by Scadding, Boorse, and Kendell (cited earlier), the pre-eminent defender of a (partly) naturalistic model of mental disorder is Jerome Wakefield, whose “harmful dysfunction” model must serve as a point of reference for any further elaboration.

Wakefield’s model both derives from and elaborates on the prior models of Kendell and Boorse. Unlike Boorse, he does not build his theory on the terms “disease” and “illness,” arguing that the attempt to distinguish these stretches the limits of the

\(^\text{111}\) For writers in the philosophy of medicine arguing that health is an essentially evaluative concept, see, for example, H. Tristram Engelhardt, “The Disease of Masturbation: Values and the Concept of Disease,” and Lester S. King, “What is Disease?” both in Caplan and Engelhardt [eds.], Concepts of Health and Disease: Interdisciplinary Perspectives.
ordinary-language use of these terms. Rather, he adopts the modern *DSM* terminology of “mental disorder” and argues that a valid mental disorder must both reflect natural dysfunction and that this dysfunction must be understood as harmful. Wakefield defends the first category as value-free, and states that only the second involves the application of values:

> I argue that disorder lies on the boundary between the given natural world and the constructed social world; a disorder exists when the failure of a person’s internal mechanisms to perform their functions as designed by nature impinges harmfully on the person’s well-being as defined by social values and meanings.\(^{112}\)

Wakefield is clear, then, that “mental disorder” is an essentially evaluative concept since a dysfunction is only judged a disorder if it is understood by the affected individual and/or by others to be harmful in some way (a dysfunctional process which accidentally confers advantage, or goes unnoticed, would not, in ordinary language, be considered disorder). Neither Wakefield nor, to my knowledge, any other writer in contemporary philosophy of psychiatry argue that “mental disorder” is a *completely* value-free or naturalistic concept. What Wakefield does argue, strenuously against multiple critics, is that “dysfunction” is value-free and that “mental disorder” is therefore not *only* an evaluative concept which reflects the prevailing moral views of a group or culture. Wakefield grounds his use of “dysfunction” in evolutionary biology, arguing that a dysfunction is “the failure of an internal mechanism to perform a natural function for which it was designed [by evolution].”\(^{113}\)

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\(^{113}\) Ibid., 374.
Though Wakefield has been read as and criticized for assigning a teleological structure to the evolutionary process through his repeated use of “purpose” and “design,” he makes clear that these terms are appropriated “metaphorically” from ordinary language about artefactual design and should not be taken literally when applied to evolution; language of “design” is “a convenient way of talking about the fact that, like artifacts, organisms’ species-typical mechanisms have the unusual property of having been shaped by their own past effects.” In the case of artifacts, we understand “design” as that which exists in the mind of the designer/creator; in the case of the natural world, in which (Wakefield holds) no such creator/designer exists, “design” is only a metaphorical way of describing the curiously pervasive phenomenon of effect-explanation. A “natural function” is therefore not a function intended by a designer but, rather, “an effect of the organ or mechanism that enters into an explanation of the existence, structure, or activity of the organ or mechanism.” Only, then, when a mechanism or organ (e.g., the eye) fails to produce the effect (e.g., sight) for which it was apparently selected in the evolutionary process, and when this dysfunction is judged harmful, is a disorder present. Importantly, for Wakefield, one need not have a precise

115 Responding to a critic on this point, Wakefield makes clear that “I do not embrace the Argument from Design, I am not a deist, I do not believe there is a plan to nature, and a I do not believe that evolution has any intrinsic directionality. Evolution is indeed directionless, non-teleological, and materialistic. There remains a millenia-long mystery as to why organisms look so much as if they were designed. The Argument from Design is invalid, but is based on legitimate observations of similarities between artifacts and organisms.” (Ibid., 975). While it is not the point of this chapter to engage Wakefield’s theological views, it is at least worth noting that his apparently a priori (not found, at least, in his published arguments) exclusion of a designer of nature makes his effort to account for “dysfunction” more complicated, since he must continually account for why his use of key (and perhaps irreplaceable) terms like “design” and “purpose” is metaphorical and cannot be literal.
116 Wakefield, “Concept of Mental Disorder,” 383.
account of a mechanism, or a precise knowledge of evolutionary development (an account, for example, of the selection pressures which influenced the differential propagation of particular traits and/or structures) to gainfully infer that a particular mechanism or organ does, in fact, serve a biological function:

It cannot be a happy accident that the eyes enable us to see, the legs enable us to walk, and the heart pumps the blood any more than it is a happy accident that the automobile provides transportation. The eyes therefore must exist in part because they enable us to see; that is, the fact that the eyes provide sight must somehow enter into the explanation of why we have eyes. This makes seeing a function of the eyes. Obviously, one can go wrong in such explanatory attempts; what seems nonaccidental may turn out to be accidental. But often one is right, and functional explanatory hypotheses communicate complex knowledge that may not be so easily and efficiently communicated in any other way.\[117\]

For Wakefield, then, the specification of “mental disorder” requires not only the recognition that a particular state of affairs is socially disvalued but also, importantly, recognition that the state of affairs reflects failure of a mechanism or organ to function as it was designed by evolution. Practically, this has rendered Wakefield both a defender and critic of the modern DSM. He defends, in part, the modern DSM’s account of mental disorder, insofar as it states that disorder implies dysfunction, and also defends the

\[117\] Ibid. Following the work of Hilary Putnam and his own mentor John Searle, Wakefield in later work argues that function should be understood as a “black box essentialist concept,” in which category membership “is determined not by the observable properties that may have inspired us to define the concept in the first place, but by an essential property that explains the observed features.” Only biological organisms, he argues, display “puzzlingly miraculous” recursive causal processes in which they appear as if they had been designed; “it is assumed that there must be some process that explains how such benefits came to exist.” Whatever this process, “function” is a label to define its results. More specifically, therefore, “a natural function of a biological mechanism is an effect of the mechanism that explains the existence, maintenance, or nature of the mechanism via the same essential process (whatever it is) by which prototypical nonaccidental beneficial effects – such as eyes seeing, hands grasping, feet walking, teeth chewing, fearing danger, and thirsting for water – explain the mechanisms that cause them.” Wakefield, “Mental Disorder as a Black Box Essentialist Concept,” Journal of Abnormal Psychology 108 (1999): 465-472; see also Wakefield, “Aristotle as Sociobiologist: The ‘Function of a Human Being’ Argument, Black Box Essentialism, and the Concept of Mental Disorder,” Philosophy, Psychiatry, and Psychology 7 (2000): 17-44.
possibility of (partial) value-neutrality in psychiatric diagnostic classification.\textsuperscript{118} He criticizes the DSM, however, for not reflecting in its own diagnostic categories the “dysfunction” requirement specified in its own definition of mental disorder. This leads, he charges, to widespread overmedicalization of normal states of human life.\textsuperscript{119} His most trenchant criticism (most detailed in a collaboration with Allan Horwitz), already mentioned above, has been of the DSM category of major depressive disorder, which (in an effort to improve interclinician reliability and in recognition of the lack of clear boundary-markers) mostly removed the distinction, longstanding in medical and psychiatric literature, between depression which reflected normal human responses to loss and between depression in which sadness (and related phenomena) seemed disproportionate to any loss and for which a biological, “endogenous” dysfunction was inferred (melancholia). The modern DSM, Wakefield and Horwitz argue, has given modern psychiatry a nosology unable to differentiate normal sorrow from melancholia, inappropriately casting (severe) normal sorrow as a medical concern and falsely inflating the true prevalence of (dysfunction-reflecting) depressive disorder.\textsuperscript{120}


\textsuperscript{120} Allan V. Horwitz and Jerome C. Wakefield, \textit{The Loss of Sadness}; see also Wakefield, “The Concept of Mental Disorder: Diagnostic Implications of the Harmful Dysfunction Analysis,” \textit{World Psychiatry} 6 (2007): 149-156.
2.3.2 “Values-Based” Accounts of Mental Disorder

Naturalistic and semi-naturalistic accounts of mental disorder have always been in conversation with a series of accounts which hold that judgments about health and disease, and by implication judgments about disorder, are irreducibly evaluative and that the values relevant to their articulation must therefore be made manifest. Although Engelhardt and Sedgwick, among others, have consistently championed evaluative accounts of disease and health, the two most prolific champions of “values-based” accounts of mental disorder within the modern philosophy-of-psychiatry literature are K.W.M. Fulford and John Sadler, whose views are briefly considered here.

Fulford, a psychiatrist and philosopher who studied at Oxford under Mary Warnock, Geoffrey Warnock, and R. M. Hare, situates his account of mental disorder in the context of intramural debates within Oxford analytic philosophy and specifically within philosophical value theory. In *Moral Theory and Medical Practice*, based on his doctoral dissertation, Fulford attempts to stand Boorse’s theory of disease and illness on its head. Contra Boorse, who claimed that disease is a theoretical value-free concept and that illness denotes the subset of disease disvalued by the social group, Fulford argues not only that disease is a value-laden concept but that disease is in fact, in ordinary language and use, best conceived as a subclass of illness. Boorse and the other

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121 Engelhardt, “The Disease of Masturbation: Values and the Concept of Disease.”
124 Of note, both Boorse and Fulford distance themselves from a too-rigid distinction between disease and illness in later work, and Boorse has later amended his work to argue that illness is best thought of not in specifically valuational terms but rather as “systemic incapacitation.” Boorse, “A Rebuttal on Health,” 47.
naturalistic thinkers, Fulford consistently charges, *ostensibly* eschew any evaluative language in their concepts of disease (or, for Wakefield, “dysfunction”) but in fact *employ* evaluative and even teleological terms such as “failure” and “goal” in their descriptive work. Fulford names the descriptivist claim (a claim not itself made by Boorse or Wakefield but which Fulford traces most proximally to G. J. Warnock) that in some cases morally evaluative language may be hidden by being defined according to the descriptive criteria for the value judgments it expresses,125 but argues that even were this a successful philosophical strategy, a descriptivist account of mental disorder (not requiring specific evaluative language) would not be tenable since descriptivist accounts are only stable under conditions of shared values (in which, to take Fulford’s use of an example by Boorse, one can refer to a stock price as “better by 5/8” or “higher by 5/8” without loss of meaning). But because human values are “characteristically and legitimately diverse” with regard to psychiatric practice and diagnosis, the essentially evaluative nature of mental disorder cannot be so disguised.126 This leads Fulford to propose a program of “values-based medicine” in which the values relevant to medical practice are explicitly recognized, named, and balanced.127

Fulford rejects attempts by normativist thinkers to render “dysfunction” as a value-free concept. “Dysfunction,” he argues, is value-laden not only because accounts

of function often employ frankly evaluative and/or teleological language such as “purpose” and “goal” but also because many commonly accepted examples of mental disorder (e.g., delusional disorder, personality disorders) pertain to the agent as a whole and therefore resist functional analysis.\textsuperscript{128} It is therefore, for Fulford, (value-laden and subjective) “illness” which is the “conceptual root notion” of medicine, with various uses of “disease” in ordinary language specifying subsets of illness.\textsuperscript{129} Furthermore, for Fulford, illness is most fruitfully understood (and used in ordinary language) not as a failure of function (presupposing some prespecified account of part-function) but rather a failure of ordinary action in the absence of obstruction or opposition, with the implication that the intention of the agent is somehow thwarted.\textsuperscript{130}

Fulford’s “values-based” work finds close kinship in the work of American psychiatrist John Sadler, whose 2005 \textit{Values and Psychiatric Diagnosis} provides not only a constructive argument about the evaluative nature of psychiatric diagnostic classification but also a lively and reasonably comprehensive review of all of the historical, political, and philosophical controversies surrounding the modern \textit{DSM}.\textsuperscript{131} In this and other works,\textsuperscript{132} Sadler argues that psychiatry should be more transparent about both its politics and its motivating values: “psychiatry has continued to avoid, deny, or minimize its intrinsic and unavoidable commitments to ideas about the Good – namely,

\begin{itemize}
\item Fulford, “What is Mental Disease?,” 83; Fulford, \textit{Moral Theory and Medical Practice}, 89-108.
\item Fulford, \textit{Moral Theory and Medical Practice}, 67-71.
\item Ibid., 109-140.
\end{itemize}
how to live well and how to get on with living well.”$^{133}$ His account of how diagnosis should do this is wide-ranging, but includes specific consideration of eudaimonia.

Discussing the need for assessing cultural context in making judgments about gender differences, he argues that “the issue of legitimating gender differences in normality or psychopathology has to do with a vision not only of biology but also of the good society, or more particularly, what the contribution to society and culture should make to eudaimonia, that is, the state of the ‘good life’ or holistic wellbeing. That is, notions of the social good are the conceptual background that permit the judgment of normal or pathological.”$^{134}$ To frame a problem as a medical problem, Sadler argues, might obscure this essential context:

> What . . . is most toxic about medicalization of social ills is not its direct social impact . . . but rather the more encompassing reduction that medicalization perpetuates and the seduction of its way of structuring social problems. Medicalization reduces the pursuit of the good life to a technical problem that can be overcome by technological means – in our case, mental health treatment . . . In so doing, the individual’s responsibility, engagement, and meaningful action in the social world is marginalized.$^{135}$

The “assumed and unacknowledged vision of the good life” which psychiatry perpetuates is, for Sadler, relief of individual suffering without recourse to a broader sociopolitical vision.$^{136}$

Psychiatric diagnosis, argues Sadler (reading Heidegger and Dreyfus), should not reduce clinical practice to a “technological mode.” Clinical practice is broader and deeper than diagnosis:

$^{133}$ Sadler, Values and Psychiatric Diagnosis, 5.
$^{134}$ Ibid., 239.
$^{135}$ Ibid., 239-240.
$^{136}$ Ibid.
Diagnosis is not a tool to settle discussion and treatment planning, but to open up discussion and treatment planning. Diagnosis is not a fact to be administered to the patient, but the concern to leaven one’s care of the patient. Diagnosis is a clue to response to treatment, not the condition of a response to treatment.  

Near the end of his work, Sadler offers a prescriptive “aesthetics of diagnosis.” Psychiatric diagnosis should “provide a simple characterization,” should “involve ongoing reinterpretation,” should “forge clinical understanding and moral purpose into therapeutic action,” should “respect the patient,” should be “faithful to the ‘data,’ to the patient, to the context, to procedure.”

2.3.3 Pragmatist/Pluralist Accounts of Mental Disorder

The nondogmatic stance which Sadler assumes with respect to “mental disorder” shares common ground with a group of other contemporary philosophy-of-psychiatry thinkers whose work reflects, explicitly or implicitly, a pragmatist stance toward diagnosis. Although their methods, intellectual sources, and conclusions vary significantly, I have chosen to lump them together here to give the unacquainted reader a brief glimpse at several influential voices within contemporary philosophy-of-psychiatry debates.

One pragmatic view is put forth by British philosopher and psychologist Derek Bolton, who directs his book-length treatment of mental disorder argues for the irreducibility of the concept of mental disorder to any one explanatory model. Bolton attends especially to the naturalistic models of Boorse and Wakefield, arguing that,

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137 Ibid., 348.
138 Ibid., 423-428.
139 Derek Bolton, What Is Mental Disorder?
among other things, the kind of theoretical demarcation (between theoretical “disease” and clinical practice for Boorse, or between “dysfunction” and “disorder” for Wakefield) required for successful application of the theory are not in fact applicable to everyday clinical practice:

In practice it seems that the distinction [between disorder and normality] is not drawn by means of complex evolutionary theoretic models related to brain/mind functioning, but on more available phenomena including apparent lack of appropriateness, purpose, rationality or meaning of mental states and associated behaviour. These are the kinds of criteria invoked in the psychiatric manuals, and, like deviance from indeterminate population norms, they are apparently not matters of absolute fact but are flexible.\textsuperscript{140}

Clinicians and patients alike, Bolton argues, demarcate disorder not according to theory (or etiology) but according to the phenomena, “psychological/behavioral dysfunction in the here and now.” There need be no conceptual wedge driven between disorder and dysfunction, distress, or disability; the description of a particular state of affairs as “dysfunction” might draw flexibly from any of several criteria (“distress/disability, deviation from normal functioning in various, flexibly quasi-statistical and idealized senses,” etc.\textsuperscript{141}) on grounds that are psychological, personal, and social, not “natural” in some abstract sense. The point of psychiatric diagnosis is not to recognize dysfunction but rather to recognize the need to treat; the medical is “defined fundamentally by a distinctive kind of response to problems, rather than by a distinctive kind of problem.”\textsuperscript{142}

Such an argument, he concedes, is vulnerable to sociopolitical “antipsychiatry” critique, but he argues that the appropriate response to avoid psychiatric is not to draw tighter

\textsuperscript{140} Ibid., 161.
\textsuperscript{141} Ibid., 175.
\textsuperscript{142} Ibid., 194.
conceptual boundaries around “dysfunction” but rather to safeguard “democratic institutional protection of human rights.”  

The concept of “mental disorder” should be flexibly applied to particular situations “not in terms of correspondence or otherwise with absolute facts of the matter” but according to whether such characterization is a pragmatically helpful description.  

A different broadly pragmatist account of nosology is offered by philosopher Peter Zachar, whose broader project has been to argue for the indispensability of psychological concepts within psychiatric practice but who in a series of articles has argued against the conception of psychiatric disorders as “natural kinds.” Such thinking, Zachar argues, is endemic within the medical model of psychiatry, which seeks to “carve nature at her joints” by uncovering essential mental disorders which can then become the targets of medical intervention. But this view, Zachar argues, holds neither for mental disorders nor for diseases in general, which are defined in ordinary language not by essence but by a wide variety of descriptive and analytic criteria (etiology, syndrome, prognosis, etc.). Nor are psychiatric syndromes “natural kinds” simply because they can be measured, because the “observations” recorded by such measurement (e.g., psychological statistics) cannot be understood independently of the theory which guided the measurement to begin with. But Zachar does not endorse what he terms a fully “nominalist” view of mental disorder which would deny any regularity to pathological

143 Ibid., 227.
144 Ibid., 258. A related pragmatist account is offered by Rachel Cooper, who argues that for a condition to be a disease it must be valued negatively, that the sufferer must be unlucky, and the condition amenable to medical treatment, either now or in some desired future. Rachel Cooper, Psychiatry and Philosophy of Science (Montreal and Kingston: McGill-Queens University Press, 2007), 39.
presentations apart from the imposed categories of an observer. The truth, rather, is somewhere in between; psychiatric disorders are “practical kinds,” naming non-essentialist regularities which reflect the pragmatic needs of the observer at any given time. They reveal regularity, but this regularity is not context-independent nor perfectly reliable.146

Other broadly pragmatist accounts of psychiatric classification, distinct but similar enough to each other to be considered together here, are offered by philosophically trained American psychiatrists Nassir Ghaemi and David Brendel. Both Ghaemi and Brendel are influenced by C. S. Peirce. Ghaemi, influenced as well by the “four-perspectives” account of psychiatry offered by McHugh and Slavney,147 by the psychoanalyst Leston Havens, and by the psychiatric writings of Karl Jaspers, argues that Engel’s biopsychosocial model has degenerated in modern clinical practice into a “lazy eclecticism” leading to theoretically careless decision-making: “If one truly holds that all psychiatric illnesses are biological, psychological, and social (especially if one believes that they are equally all three), then it would seem to follow that everyone should receive

147 Paul R. McHugh and Phillip R. Slavney, The Perspectives of Psychiatry, 2nd ed. (Baltimore, Md.: The Johns Hopkins University Press, 1998). McHugh and Slavney’s work is intended as a conceptual introduction to psychiatry for clinicians in training and argues that psychiatry must be understood through four non-overlapping “perspectives”: the “disease perspective,” holding to a traditional medical model; the “dimensional perspective,” responsive to continua rather than essentialistic categories; the “behavior perspective,” responsive to behaviorally-oriented psychology, and the “life-story perspective” with a narrative focus. Clinicians, they argue, need to keep all four perspectives in mind during clinical work, but will find that particular clinical situations provide a better “fit” with one of the perspectives, rendering the others less functionally important for the clinical encounter.
both biological and psychosocial treatments (treatments by both medication and psychotherapy).

In its place, clinicians should adopt a “principled pluralism” in which “multiple independent methods are necessary in the understanding and treatment of mental illness; no single method is sufficient. While all methods are partial or limited, they should be applied separately and purely – in this way pluralism differs from eclecticism.”

David Brendel structures his philosophical exploration of psychiatry in an intentionally pragmatic frame, arguing that psychiatric explanation and classification should adhere to the “four p’s” of pragmatism: they are practical, pluralistic, participatory, and provisional. Such an approach, he argues, can save psychiatric practice from the traditional “science vs. humanism” split which, he argues, has run through the history of psychiatry.

2.4 The Inescapable Politics of Psychiatric Practice

In an often-quoted exchange after the publication of DSM-III, psychologist Thomas Schacht accused DSM-III Task Force chair Robert Spitzer with hiding the inescapably political nature of the new classification. DSM-III sought to present itself as a scientific document, Schacht argues, but also carries the political functions of drawing distinction between the “mentally ill” and the healthy, of regulating both clients’

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149 Ibid., 15.
and professionals’ access to social resources, and of setting the boundaries in professional turf-battles. Schacht holds that in “traditional wisdom,”

idealized modern science represents objectivity and stresses the value of the empirical and the rational. This ideal science seeks after truth and seeks to control phenomena only as a means to further understanding of their essential nature. Politics, in contrast, represents subjectivity and special interest; it values the demagogic and emotional as well as the empirical and rational. Rather than seeking knowledge for its own sake, politics seeks power and seeks knowledge primarily as a practical means to power. Politics seeks control of events not as a means to understanding but as an end in itself.152

Schacht acknowledges the undermining of this dichotomy by modern philosophy-of-science heavyweights such as Kuhn and Feyerabend, and argues that DSM-III be understood flexibly as “both a tool for the production of scientific knowledge and an instrument of rhetoric, social organization, and power distribution.”153 One can think about DSM-III “in a way that transcends dichotomy and permits elective focus on science or politics, while maintaining awareness that one or the other aspect is, at the moment, implicit and not mandatorily absent.”154

Spitzer, in an accompanying rejoinder, retorts that he does not suffer from the “politics-science dichotomy syndrome (PSDS).” To defend DSM-III as a nonpolitical, scientific document in the way that Schacht conceives science and politics would, Spitzer argues, be absurd. In fact, Schacht’s paper did not go far enough in describing the essentially political nature of DSM-III. Not only are Schacht’s allegations true but also, Spitzer argues, DSM-III was developed with specifically ideological considerations in mind (e.g., the heated debate with psychoanalysts over the retention of “neurosis”), that

152 Ibid., 515.
153 Ibid., 520.
154 Ibid., 521.
Task Force members often disagreed and that decisions were therefore made as a result of subjective judgments, that rhetoric and power-tactics were used to resolve nosological controversies, that involvement in the DSM-III Task Force itself brought certain professional benefits to its participants, and that *DSM-III* had become an important source of publishing revenue for the American Psychiatric Association. Schacht’s article, Spitzer charges, “has unfortunately obscured discussion of the real issue of politics and *DSM-III*: whether the blend of politics and science has been professionally responsible or irresponsible.”

The central truths of this exchange, which remain true of the more recent editions of the *DSM* and of any other extant psychiatric diagnostic classification, provides an answer for why a chapter which began with such a simple question – “what counts as mental disorder?” – has required such a long engagement with the history and philosophy of diagnostic classification, an engagement which itself only scratches the surface of the relevant debates. If “biological psychiatry” were able to ground its clinical practice with reference to neurobiology alone, then this engagement would not have been necessary – but it cannot. If the recognition of various states of affairs as “mental disorder” had been a linear march of scientific progress marked by therapeutic triumph and broad social agreement, then this engagement would have been much shorter – but that has not how psychiatric diagnostic classification has unfolded. We are left, in contemporary mental health care, not with anything resembling Schacht’s “idealized modern science” but rather with a complicated socio-politico-scientific culture in which the cries of the

distressed, the methods of modern scientific inquiry, the economic powerhouse of modern medical and pharmaceutical interests, the self-interests and professional commitments of clinicians, and the wide range of sociocultural attitudes toward madness are inextricably mixed together. To acknowledge this is not to argue that modern psychiatric diagnosis is nonscientific or that psychiatry is only a mechanism for social control. It is, rather, to argue that insofar as we make scientific judgments, design nosologic systems, and organize systems of care, we do so within this complicated context. Likewise, when Christians attempt to think through the appropriate uses of psychiatric technology in the context of Christian soul-care, we do so within this complicated context. There is no other way. It is for this reason that the following two chapters turn to the work of Alasdair MacIntyre, whose work provides a helpful way to describe this complicated sociopolitical context and – if this project is executed successfully – prepares the conceptual soil from which a Thomistic Christian account of the use of psychiatric technology can fruitfully emerge.
American psychiatry over the last half-century, as described in detail in the last chapter, has witnessed a persistent dialectical interchange between those who speak on behalf of the profession, on one hand, and critics who seek to challenge the basic structures of psychiatric practice, on the other. The first generation of these critics, such as Thomas Szasz, R. D. Laing, and Michel Foucault, though personally disconnected from one another and widely divergent in mode of argumentation and political/philosophical context, were collectively understood as proponents of an “antipsychiatry” movement. As described in detail in Chapter 2, the common thread of these thinkers, despite their considerable diversity, was (and, for Szasz, still is) a Nietzschean suspicion that the medical/healing vocabulary of psychiatric practitioners serves as a front for the acquisition and maintenance of power over the “mad” or “mentally ill” either by psychiatry or by a culture which uses psychiatry for particular ends. Foucault, for example, arguably the most elegant of these “antipsychiatry” critics, argues that modern culture “confines insanity within mental illness” and relates to those designated as “mentally ill” only through the oppressive “abstract universality of disease.”

For Foucault, modern psychiatry perpetuates the confinement and exclusion of those who are “mad”/deviant; because this confinement is cloaked in therapeutic language, it is less visible and therefore all the more insidious.

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1 Please note that a version of this chapter has been published as Warren Kinghorn, “Whose Disorder? A Constructive MacIntyrean Critique of Psychiatric Nosology,” *Journal of Medicine and Philosophy* 2011 Feb 28; doi: 10.1093/jmp/jhr006.

The American psychiatric guild has only rarely directly engaged the central claims of the “antipsychiatry” thinkers, preferring (successfully) to ignore them and/or to render them marginal and increasingly irrelevant to professional conversations. Indirectly, however, the persistent criticisms by the “antipsychiatrists” of the regnant systems of psychiatric diagnosis influenced the paradigm shift in psychiatric nosology manifested by the descriptive criteria-sets of the third edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* in 1980. Since that time, as has been noted, foundational critics of psychiatry have been less influential and less visible. They have not, however, disappeared. Foundational critics of psychiatry have arisen both inside and outside (Jerome Wakefield, Herb Kutchins, Stuart Kirk, Carl Elliott) the psychiatric profession; while these contemporary critics often cannot be lumped with the early “antipsychiatrists,” they share the early critics’ concern that psychiatry, and particularly psychiatric diagnosis, is vulnerable to becoming a front for powerful cultural forces (for example, the pharmaceutical industry) seeking to acquire wealth and power at the expense of the “mentally ill.”

The response of the psychiatric guild to these newer critics has been mixed. Some respectful and mainstream critics, such as Wakefield, have been actively engaged in the *DSM-5* revision process; others, such as Elliott and Breggin, have been largely

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ignored. But to any who would charge that the DSM is an inherently political document which cloaks will-to-power in a therapeutic garment, the response of the guild is clear: the DSM is a scientific document which, having solved the problem of diagnostic reliability in DSM-III, will achieve progressive validity in DSM-5 and subsequent editions. The arguments of John Sadler, K.W.M. Fulford, and others that no nomenclature can be morally neutral and apolitical has not, as of now, been acknowledged or reflected in any of the official statements of the key architects of DSM-5.

Having briefly reviewed key criticisms of the DSM and several important philosophy-of-psychiatry debates in the last chapter, I seek in this chapter to offer Alasdair MacIntyre’s tripartite typology of moral reasoning, most clearly set forth in *Three Rival Versions of Moral Enquiry*, as a tool for the conceptual analysis of modern psychiatric nosology. Central texts of the DSM project, including those of the DSM itself, I will argue, display many characteristics of MacIntyre’s *encyclopedia*. Insofar as they do, however, they open themselves perpetually to the critique of neo-Nietzschean *genealogy*, a type nicely exemplified in the foundational criticisms of the “antipsychiatrists” and their ideological heirs. But MacIntyre offers a third logical type, that of *tradition*, in order to defend the rationality of moral reasoning against genealogical critique. MacIntyre’s typology provides an analytic model for understanding

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contemporary debate about the DSM project which is parsimonious, which accurately accounts for both the strengths and weaknesses of the DSM project, and, importantly, which does not depend for its coherence on the existence and recognition of “values” distinct from “facts,” a binary distinction which unnecessarily complicates the related work of Fulford and, to a lesser extent, Sadler. MacIntyre’s account of tradition, I will argue, provides a rich perspective from which to examine psychiatric nosology; the DSM project would be more truthful and therefore more useful for science were it to narrate itself as tradition-constituted enquiry rather than as encyclopedia.\(^\text{10}\)

3.1 Encyclopedic Self-Conceptions Within the DSM Project

MacIntyre begins his typology of moral enquiry, initially delivered as a set of Gifford Lectures at the University of Edinburgh in 1988, with a paradigmatic account of the Ninth Edition of the *Encyclopaedia Britannica*, which MacIntyre describes as the “canonical expression” of the philosophical/scientific culture of late-nineteenth century Edinburgh.\(^\text{11}\) The editors of the Ninth Edition, in MacIntyre’s narration, understood themselves to be continuing the massive project, begun a century earlier in *L’Encyclopédie* of Diderot, of the progressive accumulation and systematic exposition of all knowledge. Such a project presumes a unitary and positivistic account of scientific inquiry, applicable to all subject matter, consisting of four essential elements. First, there

\(^{10}\) In this paper I will refer to the various editions of the *DSM* as “the *DSM*” and those responsible for constructing them as “DSM architects.” By “the DSM project” I refer to the contemporary effort to classify psychiatric disorders of which the various editions of the *DSM* are the principal expression; the DSM project therefore includes not only the text of the *DSM* and its architects but also to the way in which the text is received and interpreted by clinicians, patients, and the lay public.

\(^{11}\) Ibid., 18.
are data, “facts,” which are open to examination. Second, methodical analysis of the facts gives rise to “unifying synthetic conceptions” which so order the facts as to show them to be exemplifying more general laws.\textsuperscript{12} Third, uniform methods are used to achieve these unifying synthetic conceptions. Fourth, there is the assumption that systematic application of these methods to facts will result in continuous progress in supplying increasingly comprehensive unifying conceptions and “fundamental laws.”\textsuperscript{13} The culture which produced and sustained the Ninth Edition, according to MacIntyre, shared the assumption that all educated persons would assent to a single conception of rationality and understood themselves as producing a progressively comprehensive account of the way things actually are in the universe.

To what extent does the DSM project resemble MacIntyre’s type of “encyclopedia” and its paradigm, the Ninth Edition of the \textit{Encyclopaedia Britannica}? There are, to be sure, important differences. The \textit{DSM} is a considerably less expansive document than the Ninth Edition, dealing only with questions of psychiatric nosology and not (directly) with questions of metaphysics or other nonpsychiatric disciplines. Beginning with \textit{DSM-III}, the \textit{DSM} takes care, ostensively at least, to be “generally atheoretical with regard to etiology,” prescinding from any general theory of psychopathology or of human functioning.\textsuperscript{14} Furthermore, unlike the Ninth Edition the \textit{DSM} represents itself as a \textit{pragmatically oriented} manual conducive to use by clinicians

\textsuperscript{12} Ibid., 20.  
\textsuperscript{13} Ibid.  
of various, and perhaps incommensurable, theoretical orientations; it does not *ostensibly* purport to collapse the differences between rival theoretical schools.\textsuperscript{15}

But these qualifications notwithstanding, there are important similarities of the *DSM* to MacIntyre’s “encyclopedia” which are useful for understanding contemporary criticisms of the DSM. In *DSM-IV-TR*, these similarities are perhaps most clearly displayed, appropriately, in the introductory description of the process by which *DSM-III-TR* was revised into *DSM-IV*. *DSM-III*, the document states, “represented a major advance in the diagnosis of mental disorders and greatly facilitated empirical research” which have, recursively, enabled the accumulation of “data sets” for most of the diagnostic categories.\textsuperscript{16} The *DSM-IV* revision process was therefore constituted by a “three-stage empirical process.” First, workgroup members conducted “systematic and comprehensive reviews” of the relevant empirical literature on each diagnosis, with the goal of attaining “comprehensive and unbiased information” upon which to make revision decisions. Second, when these literature reviews were insufficiently conclusive, the groups conducted reanalysis of previously collected data from population-based epidemiological studies. Third, the task force sponsored field trials to test the reliability and generalizability of the *DSM-IV* diagnostic categories. Nomenclature changes, while related in part to prior tradition, were to be grounded in available empirical evidence. The goal, never quite stated but clear enough, is a progressive reliability, followed by progressive validity, in psychiatric diagnostic classification.

\textsuperscript{15} American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4th ed with Text Revision* (Washington, D.C.: American Psychiatric Association, 2000). I will hereafter refer to this text as *DSM-IV-TR*.
\textsuperscript{16} Ibid.
This methodology, all consistent with a MacIntyrean “encyclopedic” self-understanding, is made even more explicit and clear in the publications to date of the central planners of DSM-5, to be published in 2013. DSM-5 architects Regier, Narrow, Kuhl, and Kupfer, reflecting on the methodological innovations of DSM-III, celebrate the “remarkable advances in research and clinical practice” facilitated by increasingly reliable diagnostic criteria. They lament, however, the lack of “clear separation” of many of the DSM-IV syndromes exposed by recent large clinical trials and the increasing prevalence of NOS (not otherwise specified) diagnoses for patients who do not quite fit into the various DSM-IV criteria sets. How, they ask, “are we to update our classification to recognize the most prominent syndromes that are actually present in nature, rather than in the heuristic and anachronistic pure types of previous scientific eras?” The answer is, as with DSM-IV, to engage in a multi-year program of scientific conferences and extensive literature reviews, with the ultimate goal of achieving an etiological, rather than a syndromal, nosology:

Mental disorder syndromes will eventually be redefined to reflect more useful diagnostic categories (“to carve nature at its joints”) as well as dimensional discontinuities between disorders and clear thresholds between pathology and normality. However, our immediate task is to set a framework for an evolution of our diagnostic system that can advance our clinical practice and facilitate ongoing testing of the diagnostic criteria that are intended to be scientific hypotheses, rather than inerrant Biblical scripture.

17 Regier et al., “The Conceptual Development of DSM-V.”
20 Ibid., 649. The view of “Biblical scripture” implied by this metaphor is, of course, grossly inadequate, and a more nuanced view of scripture might shed interesting light on the frequent colloquial descriptions of the DSM as a “psychiatric bible.” But that is not our focus here.
The encyclopedic shape of this logic should be clear. Epidemiologic data, gained largely from population-based surveys and focused field trials, provide the basis for unifying synthetic conceptions (the diagnostic categories) of the data, with clear methods defined for deriving the unifying conceptions from the data. Although it is understood that these conceptions are empirically tentative and therefore not final (“scientific hypotheses”), they are understood as place-holders on a nosological project which will eventually describe, or uncover, the very structure of nature (a nosology which achieves the Platonic goal of “carving nature at its joints”). Such, MacIntyre narrates, was the essential philosophical mindset of nineteenth century readers of the Ninth Edition of the *Encyclopaedia Britannica*.

### 3.2 Encyclopedia Subverted: The DSM and Its Genealogists

The epistemological confidence exhibited in the Ninth Edition was, in MacIntyre’s narration, permanently disrupted by Friedrich Nietzsche and his ideological heirs. Nietzsche’s *Genealogy of Morals*, originally published in 1887, concurrent with the Ninth Edition (1875-1889), provided “not only an argument in favor of, but a paradigm for, the construction of a type of subversive narrative designed to undermine the central assumptions of the Encyclopedia,” primarily by attempting to “discredit the whole notion of a canon.”21 This mode of “genealogy,” which is the second of MacIntyre’s three types of moral inquiry, is characterized by any combination of four interrelated critiques (I focus here on MacIntyre’s typological description of genealogy

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rather than on Nietzsche’s specific arguments or on MacIntyre’s detailed explication of Nietzsche. First, the genealogist issues psychogenetic critiques, arguing that “what is taken to be fixed and binding about truth . . . is an unrecognized motivation serving an unacknowledged purpose” such as, for Nietzsche, the will-to-power.\(^{22}\) Second, the genealogist issues epistemological critiques, arguing that unqualified or absolute truth-claims blind inquirers to the perspectival nature of knowledge and therefore sustain the illusion of a metaphysically coherent world. (Nietzsche’s particular contestable arguments to this effect, MacIntyre contends, are less relevant than his destabilizing introduction into philosophy of the inquiring self which both abstracts from the world and yet which can only inhabit a particular perspective.)\(^{23}\) Third, the genealogist issues historical critique, attempting “to write the history of those social and psychological formations in which the will to power is distorted into and concealed by the will to truth.”\(^{24}\) Fourth, the genealogist (starting with Nietzsche, but progressively among Nietzsche’s 20\(^{th}\) century followers) issues literary critique by rejecting the literary/argumentative form, the discursive academic treatise, which makes the encyclopedia possible.

MacIntyre argues that the genealogical project, however historically successful, is not ultimately sustainable because it corrodes not only the possibility of the accumulation and transmission of rationally ordered knowledge but also the possibility of the ordering self: “make of the genealogist’s self nothing but what genealogy makes of it, and that

\(^{22}\) Ibid., 35.
\(^{23}\) Ibid., 38.
\(^{24}\) Ibid., 39.
self is dissolved to the point at which there is no longer a continuous genealogical project."25 My purpose here, however, is not to recapitulate or to critique MacIntyre’s argument, but to look for areas of continuity between MacIntyre’s genealogical type and the modern psychiatric critics of the DSM project. To what extent do modern DSM critics carry on the genealogical project?

The first generation of “antipsychiatrists,” particularly Foucault and (with much less nuanced argument) Szasz, clearly pose genealogical challenges to the contemporary psychiatry of their day, each (in very disparate ways) asserting that psychiatry serves as a veiled front for the will-to-power of modern bourgeois culture (Foucault) or the “therapeutic state.”26 But as has been noted,27 these foundational criticisms of psychiatry per se have been less publicly visible in recent decades. Wakefield and First attribute this muting of the “antipsychiatry” movement in part to the methodological advances of DSM-III:

With the publication of DSM-III in 1980, many of the antipsychiatrists’ criticisms were squarely and systematically addressed by the psychiatric community. The inclusion in DSM-III of a definition of “mental disorder” which excluded social deviance and personal/social problems, the removal to an appendix of common nondisorder conditions which might warrant psychiatric treatment, and the inclusion of ostensibly theory-neutral diagnostic categories, together with advances in neurobiology and pharmacology, have pretty much put the psychiatry critiques to rest.28

Whether Wakefield (who, as noted in the last chapter, has served both as trenchant critic of and constructive collaborator to the DSM project) and First are correct

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25 Ibid., 54.
28 Wakefield and First, 29.
in their argument that the methodological changes of *DSM-III* converted and satisfied many who would previously have been persuaded by the antipsychiatry critiques, or whether (as a genealogist might argue) this silencing occurred in a more overtly political context (e.g., the systematic silencing of “social psychiatrists” in the 1970s) is beyond the scope of this paper to examine. However, as Wakefield and First acknowledge and as considered in some detail in the previous chapter, foundational criticisms of the DSM project continue to proliferate both among mental health practitioners and among the lay public. Foundational critique of the DSM project in the post-*DSM-III* era has been less frequently the domain of avowed enemies of institutional psychiatry – though these, including Szasz, still exist – than the domain of clinical (and often psychiatric) “insiders” who view foundational criticism of the DSM project as a way to save psychiatry from itself. The specific backgrounds, driving agendas, and methodological approaches of these contemporary critics are highly variable. Paula Caplan, writing a semi-autobiographical account of her conflict-filled experience as a consultant to a *DSM-IV* planning committee, argues that the male-dominated *DSM-IV* Task Force was dismissive of and tone-deaf to the particular ways in which certain proposed diagnostic categories pathologized the experience of women.\(^{29}\) Peter Breggin critiques the *DSM* in the service of his larger campaign against psychiatric medication, arguing, for example, that “the ADD/ADHD diagnosis [in *DSM-IV*] was developed specifically for the purpose of justifying the use of drugs to subdue the behaviors of children in the classroom.”\(^{30}\)


Philosopher Carl Elliott describes the relationship between the emergence of new nosological categories (e.g., social phobia) and the way that these categories are themselves aggressively marketed by pharmaceutical companies eager to sell medications to treat these newly described conditions.\(^{31}\) Herb Kutchins and Stuart Kirk, as discussed in the last chapter, charge that the DSM project inappropriately pathologizes everyday behavior, pathologizes and therefore further disempowers those who are already powerless and/or social disfranchised, and (as they argue in an extended critical narrative of the declassification of homosexuality in *DSM-II*) blinds itself to the important ways in which the “science” of psychiatric nosology is driven by political advocacy of various kinds.\(^{32}\)

The genealogical threads in these methodologically diverse and heterogeneous criticisms are clear upon close observation. Central to them all is the assertion, explicit or implicit, that the DSM project cloaks the will-to-power in therapeutic veil. Different critics propose different accounts of *whose* power is being enhanced, whether that of men in a patriarchal culture (Caplan), the DSM Task Force (Caplan), the American Psychiatric Association and/or American psychiatrists (Breggin, Kutchins/Kirk), and/or the pharmaceutical industry (Breggin, Elliott). But *that* the DSM cloaks will-to-power, in some form, is common to all of the contemporary foundational critiques.

The typical response of the leaders of the DSM project to these foundational critics has been to ignore them or, failing that, to attempt to discredit them and/or to

\(^{31}\) Elliott, *Better than Well.*

reassert the “scientific” nature of the DSM. Rounsaville et al. grudgingly acknowledging that a definition of “mental disorder” should be included in DSM-5 “if for no other reason, . . . because of rising public concern about what is sometimes seen as the progressive medicalization of all problem behaviors and relationships” and that, furthermore, conceptual disagreement about what constitutes disorder “will not be resolved on the basis of empirical data,” nevertheless propose further empirical survey research to better understand how clinicians and others understand and use concepts of disease or disorder, leaving unanswered the very basic question about how non-empirical conceptual disputes will be resolved.33 Indeed, the overwhelming response of the principal architects of the DSM project in response to Kutchins and Kirk, Caplan, Breggin, Elliott, and other foundational DSM critics has been one of silence.

In MacIntyre’s historical-philosophical narration, the encyclopedic mode of scholarship displayed in the Ninth Edition of the Encyclopaedia Britannica did not implode overnight in response to genealogical critique. Indeed, MacIntyre states, it is very much still with us, structuring many of the implicit assumptions of the contemporary liberal university.34 But MacIntyre argues that by exposing the “pretension involved in the unwitting elevation of the culturally and morally particular to the status of what is rationally universal” and by highlighting the structural continuities of the encyclopedic project (in his argument, of late-Victorian conceptions of morality) with its “unenlightened, uncivilized predecessors,” the genealogical critic issues the encyclopedia

34 MacIntyre, Three Rival Versions, 170-171.
a set of unanswerable challenges.\textsuperscript{35} There is no way to prove the validity of the genealogical arguments; to attempt to do so would be to domesticate genealogy into yet another modern philosophy. But genealogy rejects this confinement; the criterion of evaluation of genealogy’s success is therefore a negative one, namely the lack of convincing response by encyclopedia to genealogy’s critique, and the progressive loss of confidence in encyclopedia as a result. For MacIntyre, the history of twentieth-century philosophy displays exactly this sort of lost confidence in encyclopedia. Whether the encyclopedic aspects of the DSM project will suffer an analogous lost confidence is a matter for history to judge. The ongoing proliferation of genealogical critics, however, together with the retrenchment and widespread silence of the DSM’s architects in the face of criticism, supports, even if it does not prove, MacIntyre’s central claims.

\textsuperscript{35} Ibid., 190.
3.3 Tradition-Constitted Inquiry As Alternative to Encyclopedia

MacIntyre, however, is no nihilist, and his central project in *Three Rival Versions of Moral Enquiry*, together with his earlier *Whose Justice? Which Rationality?* is to propose a mode of moral (and scientific) reasoning capable of withstanding genealogical critique. ³⁶ “Tradition” is, for MacIntyre, a mode of rational inquiry which understands itself as a project of particular historically rooted communities, “an historically extended, socially embodied argument;” ³⁷ it therefore fully acknowledges that it is dependent on these communities for its ongoing flourishing and, correlatively, exists in the theoretical service of these communities. The paradigmatic instance of this kind of traditioned rationality is, in MacIntyre’s work, the Aristotelian-Thomist philosophical tradition, but MacIntyre never limits the kind of “communities” capable of tradition-constituted inquiry to those which are explicitly religious or philosophical. Typically, he argues, tradition-constituted enquiry will emerge in three stages. In the first, stage, a particular community confers authority on “certain texts and certain voices” which are, initially, deferred to unquestioningly. ³⁸ Eventually, however, in a second stage, these authoritative texts and voices are put to the question, either by internal dissension or external conflict, and various inadequacies are publicly exposed. These inadequacies are recognized as potentially lethal to the ongoing flourishing of the community; either they must be countered and transcended or the community will be unable to go on. In a well-

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functioning tradition, they lead to a crucial third stage, in which the previously settled truths of the community are reformulated and re-evaluated, leading to “new formulations and evaluations designed to remedy inadequacies and overcome limitations.” These reformulations are not, for MacIntyre, judgments which correspond to “facts;” they are, in good Thomist fashion, judgments which adequate the communal mind to the community’s world as the community apprehends it. In this process – which might occur, in various ways, any number of times in the historically extended life of a tradition – three important developments take place. First, institutions of various kinds are formed to regulate the tradition’s methods of inquiry and to provide space for internal dissent and debate about the goods internal to the tradition. Second, nurtured by these institutions, the community comes to recognize particular intellectual and moral virtues, or excellences, which serve to internally sustain the tradition. Third, discursive theories of various sorts emerge in the tradition’s self-narration.

MacIntyre is eager to defend this account of tradition-constituted rationality against the charges of relativism, understood as the “denial that rational debate between and rational choice among rival traditions is possible,” and perspectivism, understood as the denial that one can make truth-claims from within any one tradition. In addition to arguing that the relativist has no epistemologically neutral place from which to stand, given the suppositions of relativism, in order to make a relativist critique, MacIntyre argues that relativism is rendered demonstrably false by historical examples in which rival and competing epistemological traditions have, in fact, put each other to the

39 Ibid., 355.
40 Ibid., 352.
question and, if successful, have been put in “epistemological crisis.” The epistemological crisis, which corresponds to the second step of MacIntyre’s threefold account of how traditions develop, forces the tradition in crisis to formulate a “radically new and conceptually enriched scheme” which (a) furnishes a solution to the heretofore intractable problems, (b) explains why the tradition was vulnerable to the crisis, and (c) demonstrates continuity of the new conceptual scheme with the prior shared beliefs and thought-patterns of the tradition. The relativist challenge, then, holds only if a tradition is so culturally isolated or conceptually underdeveloped that it cannot be put to the question by another tradition.

MacIntyre readily admits, in discussing the perspectivist challenge, that tradition-constituted inquiry lacks either Cartesian or Hegelian epistemological certainty, but he argues that these are themselves philosophical fictions and strongly rejects the implication that tradition-constituted truth-claims are invalid. Tradition-constituted inquiry understands its truth-claims to be provisional, always open to future refutation and reframing – but truth-claims nonetheless. MacIntyre’s account of rational justification of truth-claims is a pragmatic one: the first principles and subordinate truths of a tradition are vindicated dialectically and historically, justified “insofar as in the history of this tradition they have, by surviving the process of dialectical questioning, vindicated themselves as superior to their historical predecessors.” Having derived truth-claims in this way, traditions are then free to regard them confidently as the best-

41 Ibid., 361.
42 Ibid., 362.
43 Ibid., 360.
available descriptions of the way things are in the world – they are therefore genuinely claims of truth – but this confidence is always tempered with the awareness that a tradition’s truth-claims, like the tradition itself, are ineradically local, and that some future unanticipated challenge could always expose them as inadequate.

Tradition-constituted inquiry, for MacIntyre, is more resistant than the “encyclopedic” model to genealogical deconstruction. First, unlike the encyclopedist, the adherent of tradition is open and forthright about the historical nature of moral reasoning; rather than defensively barricading or rejecting the past, the adherent of tradition invites the genealogist in to look around, to explore it, to discuss it. Historicist critiques, therefore, while still possible, can be treated as internal self-correcting movements in the tradition rather than as external threats. Second, the adherent of tradition can point out to the genealogist that knowledge, even knowledge of “real” things, is not neutral; it presupposes “prior commitment” to moral formation in a tradition.44 The orientation to particular perceived goods that some moral theories reify as “values” is therefore intrinsic to a tradition’s history and epistemological structure; MacIntyre can therefore account for the presence of these “values” without requiring a rigid philosophical distinction of “values” from “facts” (the latter, he famously writes, are a “seventeenth-century invention”) and without acceding to any emotivist conception that values are merely preferences for one thing over another. Third, as argued above, the adherent of tradition, unlike the genealogist, can account for the existence of a coherent self over time.

44 MacIntyre, Three Rival Versions, 60.
45 MacIntyre, Whose Justice? Which Rationality?, 357.
3.4 What Would a Tradition-Constitted Account of the DSM Project Look Like?

MacIntyre’s typological account of “tradition” is both descriptive and prescriptive: descriptive, in that he describes particular philosophical movements which *have* functioned in a tradition-bound way (paradigmatically, as above, the Aristotelian philosophical tradition as modified by St. Thomas Aquinas and other medieval thinkers and as carried on in modern Thomism); prescriptive, in that in his judgment *only* tradition will prove resistant to the corrosive critique of genealogy. MacIntyre rarely addresses psychiatry directly in his work; when he does, it is generally to attempt to highlight (in, ironically, a genealogical mode) the way in which late-modern bourgeois culture uses the “therapist” (understood as an ideal type) to “[transform] neurotic symptoms into directed energy” which enriches capitalistic production (MacIntyre 1984, 31), or to argue (contestably) for the ineradicably social and interpersonal nature of certain forms of psychopathology.46 He never directly engages the *DSM* or modern psychiatric nosology. We are left free, then, to apply MacIntyre’s typology of moral enquiry in *Three Rival Versions* to the DSM project and to ask: what would the DSM project look like if it understood itself as tradition-constituted (and tradition-constitutive) fully and without qualification, without any “encyclopedic” pretension? How would a tradition-constituted psychiatric nosology describe itself?

On one level, it is remarkable how little would need to change, either in the text of the *DSM* or in its essential functional utility. The *DSM* could still rightfully be understood as primarily a “helpful guide to clinical practice” with the additional goals of

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facilitating research and improving communication among clinicians and researchers. It could still be used by—and useful to—clinicians and researchers of various theoretical persuasions (psychodynamic, cognitive/behavioral, biological, and so on) across a variety of clinical settings. It could still be understood as a monumental synthesis of available research which is responsive to the latest empirical psychiatric research and also—as is already explicitly stated in the *DSM*—responsive to the continuation of the ongoing diagnostic tradition of which it is an installment. It could still do everything possible, using the latest cross-cultural epidemiological data, to describe both “culture-bound” mental disorders such as *ataques de nervios* from mental disorders such as schizophrenia which have approximately the same prevalence in every known culture and are therefore thought to be less bound to culture-specific environmental or genetic determinants. It could even be understood, as it already is, as part of an ongoing effort to “carve nature at its joints” in describing naturally existent mental disorders *if*, when this is claimed, it is also understood that absolute or unconditioned knowledge of such things is not possible, that any diagnostic classification is rationally (and scientifically) justified only insofar as it is able to withstand “as many questions and as many objections of the greatest strength possible,” and that no diagnostic classification can escape the historical and epistemological contingencies of its founding and originating community.47

The qualifications associated with this last claim are, of course, very large “ifs,” and begin to point out the essential ways that a tradition-bound understanding of psychiatric nosology, and in particular of the DSM project, differs from an encyclopedic

one. The most foundational difference is that in a tradition-constituted account, no text or form of argument can be dissociated, even in principle, from the concrete community (or communities) which produced it and which continues to use it for the political structuring of its communal life. A tradition-constituted account would therefore argue that it is no accident that the *DSM* is produced by the American Psychiatric Association, rejecting the view that the same document could just as easily, given slightly different historical contingencies, have been produced by a U. S. government agency, or by the World Health Organization (which publishes the closely related *International Statistical Classification of Diseases and Related Health Problems*), or by a professional organization in a different mental health discipline such as clinical psychology. In a tradition-constituted view, the *DSM* is unintelligible apart from the APA and it must therefore fully own that patrimony (the gender-exclusivity of that term is noted). It was and is produced by psychiatrists (in limited collaboration with other nonpsychiatric professionals and patient-advocacy groups) for the advancement of psychiatric practice and research. It is, as such, a powerfully useful and helpful document, increasingly reliable in its formulation and “valid” in its stated aims. But its dependence on this originating community leaves it fully open to the contingencies, and the moral failures, of that community as well. What matters to psychiatrists, after all, fully permeates every aspect of the document’s construction and use, from the way that conceptual questions are framed, to the way that field trials and epidemiologic surveys are constructed and conducted, to the way that work groups are assembled, to the way that diagnostic criteria are written, to the way that these criteria sets are included or excluded in the final
classification, to the way that the document is marketed both to clinicians and to the lay public, to the way that it is read by patients and clinicians alike. If the originating community of the document were to demonstrate what in retrospect is understood as a collective moral lapse – if, for example, commercial pharmaceutical interests were inappropriately to dominate the psychiatric research enterprise and psychiatric clinical practice – then it would be no surprise (indeed, it would be fully expected) for that lapse to be somehow embodied in the DSM. In this, a MacIntyrean approach would largely cohere with the prior work of Fulford and Sadler (described in the previous chapter) that “values” cannot be separated from psychiatric nosology and clinical practice. But these approaches, in a MacIntyrean context, are not radical enough in that they both presume and use (though not without question) the modern distinction between “fact” and “value,” a distinction which, for MacIntyre, lies at the root of the encyclopedist project. Paradoxically, that is, an approach which argues for the ubiquity of “values” in psychiatric practice nevertheless makes possible the chimerical pursuit of a nosology which is value-free. But MacIntyre’s Aristotelian functionalism renders this distinction superfluous, and therefore provides an even more resilient refutation of an encyclopedist account of nosology.

A tradition-constituted account of the DSM would continue to uphold it as a “scientific” document, but it would be understood as “scientific” in a way fundamentally different from an encyclopedic account of “science.” In an encyclopedic frame, to charge that the DSM is a fundamentally political document, as most of its contemporary foundational critics do, is to challenge its status as a work of science, which is not itself
understood as a political enterprise. Because this is tantamount to threatening its overall legitimacy, such charges tend to be met either with silence or, failing that, with defensive efforts to highlight the DSM’s empirical ground. But from the tradition-constituted view, such retrenchment displays a deep misunderstanding not only of the DSM but of science in general, and particularly of complex human sciences such as psychology and psychiatry. For the adherent of tradition, all science is fundamentally political, in that it cannot ultimately be extracted from the political needs and contingencies of its originating and sustaining polis. Charges that the DSM is somehow “political” therefore do not, for the adherent of tradition, challenge in any way its “scientific status;” they only state the obvious. Foundational criticisms of the DSM can therefore be understood as internal, not external, challenges, and therefore treated as such. Charges such as those of Caplan, for example, that the (now-defunct) diagnostic constructs of “masochistic personality disorder” and “self-defeating personality disorder” were biased against the experiences of women, should prompt, for a tradition-constituted DSM project, a good deal of non-defensive soul-searching. How might the dominance of men among late-20th-century psychiatric theorists and practitioners, it might be asked, have influenced the development of American psychiatric nosology? How might longstanding cultural tendencies to ascribe responsibility to female victims of sexual violence, particularly repeated violence, have influenced this trajectory? There are no objective or politically neutral ways to frame these questions – even my own choice of words here expresses on some level the formative clinical and moral communities of which I am a part. But they are both empirical and political questions, not one or the other. Furthermore, in a
tradition-constituted account they are fundamental questions, not of the scientific status of the DSM, but of its scientific validity: if what matters to a community necessarily affects its analytic view, then distortions in or abuses of what matters to the community would be expected to result in distorted (and therefore invalid) scientific judgments (though with the understanding that there is no account of “validity” which is not perspectival and tradition-dependent). Seen in this light, the messy and even violent political struggle which resulted in the removal of homosexuality per se from DSM-II in 1973/1974 should not be understood, as partisans on both sides of the issue have alternately claimed, as a “triumph of politics over science.”48 It might, as Ronald Bayer and others have argued, be regarded as a time when American psychiatry was taught the hard lesson, against its encyclopedic instincts, that psychiatric diagnosis is inescapably political, and that it might as well own up to that ineliminable fact.49

A tradition-constituted understanding of the DSM project would entail an epistemological humility which is generally compatible with the text of the DSM itself but which is quite foreign to the way that the text is promoted and received both by clinicians and by laypersons. In a tradition-constituted account the DSM is not, emphatically, a timeless or culture-free account of disorders which exist in some sort of metaphysically abstracted reality. Such presumption to an “absolute view” of psychopathology, even one which is known now only in part, is an essentialist myth. The DSM is, rather, from cover to cover a pragmatic manual of clinical practice, bound to a

particular time and cultural context, and exists as the expression of a particular community’s way of “going on” in research and patient care. Every aspect of it, from its mode of organization to its definition of “mental disorder” to its relation to empirical research to its specific diagnostic criteria, is fully implicated in time and culture and cannot be understood apart from it.

Two implications follow from this. First, it is a very dangerous enterprise to attempt diagnosis across temporal or cultural divides, for instance by asking if the young women whom the early Freud treated or shell-shocked World War I veterans “actually” suffered from post-traumatic stress disorder. If one were to claim this, one says no more – and no less – than that “we,” in our current cultural and temporal context, can narrate the experience of others more adequately than those of their own time and place. It does not mean that our formulation is any less culturally conditioned; for MacIntyre, the limitations of a tradition’s formulations are known only in retrospect, having been judged inadequate in the light of newly posed questions – but no tradition’s truth-claims are exempt in theory from this sort of disqualification.

The second implication, which I will call the requirement of moral transparency, follows from this, and it is here, perhaps most of all, where the DSM project falls short of MacIntyre’s requirement for tradition-constituted inquiry. As discussed above, because a tradition-constituted DSM would acknowledge that it is a pragmatic political-scientific guide to the ongoing practice of a particular therapeutic community, and because it would acknowledge that what matters to that community will find inevitable expression in the

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content of the manual, it will therefore would find no use for any rigid separation of “facts” and “values,” as if one could be derived, and known, apart from the other. Because of this, it would recognize that the DSM is an essentially and ineradicably moral document in that it is permeated by these structuring and sustaining communal “matterings.” (The eschewal of “theory” in DSM-III and beyond was an essentially pragmatic move to broaden the political accessibility and appeal of the DSM and to prompt more coherent research programs. It did not entail, nor is it compatible with, “value-neutrality”.) If this is the case, though – if the content of the document cannot be coherently understood apart from what matters to its originating community – then what matters to the originating community, insofar as the community itself understands this, should be clearly presented within, or at least alongside, the text, for the benefit of prospective readers and interpreters. The DSM project, like any other community, should be open to and transparent about its formative moral sources.51

There are two principal obstacles to this moral transparency. First, it almost goes without saying that a broad-based, “atheoretical,” minimalist diagnostic taxonomy like the DSM – itself designed to hold together adherents of rival clinical viewpoints – is both created and used by clinicians and laypersons who differ in many ways. Beneath the enforced unity of the DSM, in other words, seethes a cauldron of moral disagreement. In one sort of MacIntyran view, this is damning of the DSM, exposing its encyclopedic pretensions and the moral fragmentation of the culture which uses it. But this is not the only possible MacIntyran interpretation. An analysis of the DSM from the perspective

of tradition-constituted inquiry would rather ask why, if the DSM only masks the moral fragmentation of its users, it retains its social and political power. Surely, one might reasonably say, there are some common aims of those who produce and/or use the DSM which account for its ongoing influence; what are they? A shared clinical vision? A desire for standardized payment for services rendered? Commitment to a common research project? Insofar as these shared “values” or “matterings” are appreciated, they should be transparently named.

This leads to the second obstacle to the moral transparency of the DSM, namely, that often humans do not know why we do what we do; what matters to us may not be what we think matters to us, or even what we want to matter to us. Anyone with even a grudging appreciation of psychotherapy, almost regardless of particular theoretical mode, can readily attest to this; and psychoanalysis here provides a helpful metaphor. The whole point of psychoanalysis is, in Freud’s classic expression, to “make the unconscious conscious;” to allow the analysand, through habituation in reflective practice, to become more aware of previously un-owned and un-experienced “mattering.” The process of analysis allows the self which was previously opaque to itself to be better integrated into its world and therefore more resilient to ongoing challenges. Traditions of discourse, one could plausibly argue from a MacIntyrean view, ought to function in much the same way, constantly examining their own presuppositions and biases in order to become less opaque to themselves and therefore more resilient against external and internal challenge. In this way, they become less susceptible to genealogical critique, which is ultimately
effective *only* against communities and traditions which either refuse to be morally transparent or which lack awareness of their own moral sources.

The practical implication of this is that a DSM project which self-consciously understood itself as tradition-constituted would react to foundational criticism not defensively, as if its existence were threatened, but receptively, as an opportunity to develop more integrative self-awareness and moral transparency. It would also be constantly self-monitoring for previously unacknowledged areas of “mattering” which might influence its clinical judgment. It would non-defensively want to know, for example, how research funded by drug companies is influencing the development of new or refined diagnostic categories in *DSM-5* (for example, by providing the needed “evidence base” for the empirical justification of the category). It would want fully to understand the effect on *DSM’s* content when, as Sadler and others have pointed out, the organization which is its theoretical arbiter and scientific shepherd (the American Psychiatric Association) is financially dependent on it for publication revenue.\(^{52}\) And if, in doing so, it concludes that these material conflicts affect its judgments about mental disorders, it would be transparent about this, and it would change.

3.5 Tradition-Constitted Inquiry In Practice: Lessons for the *DSM* from the Newer Psychotherapies

I have argued that if the DSM project is to be spared, over the long term, from genealogical corrosion, it ought to understand itself as tradition-constituted rather than encyclopedic inquiry. This would, in many ways, change the *DSM* very little, but it

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\(^{52}\) Sadler, *Values and Psychiatric Diagnosis.*
would also require acknowledgement that psychiatric diagnosis is a political as well as a scientific enterprise and that the diagnostic judgments of the DSM project are therefore tied to the particular community (or communities) which originates and sustains it. Recognition of this would require a further commitment to moral transparency and to the self-reflective habits which make communal self-knowledge, and therefore transparency, possible.

This may seem a tall order, an unrealistic and idealistic expectation for the DSM project. Indeed, it may be – and if so, MacIntyre would predict that the DSM project will eventually die the slow death of any encyclopedia, as foundational genealogical critics progressively erode the confidence placed in the DSM by those who use and sustain it. But in closing, it may be of some interest to note that there exist concrete contemporary therapeutic communities which in many respects embody – almost certainly unwittingly – MacIntyre’s model of tradition-constituted inquiry. These communities share neither the universalistic pretensions of the DSM project nor the burden of providing theoretical unity to the mental health professions; they flourish, rather, within the vibrantly pluralistic world of the contemporary psychotherapies. For example, “third-generation” cognitive-behavioral therapies such as Dialectical Behavior Therapy (DBT),\textsuperscript{53} Acceptance and Commitment Therapy (ACT),\textsuperscript{54} and Emotion-Focused Therapy (EFT)\textsuperscript{55} have each developed limited theory-specific diagnostic classification which supplements

the diagnostic criteria of the *DSM*. Although their size and scope likely fall short of what MacIntyre would recognize as tradition – we might call them “sub-traditions” to distinguish them from MacIntyre’s typical examples – they nicely exemplify MacIntyre’s description of how fledgling traditions act. They each emerge from a particular therapeutic community with particular needs (e.g., psychotherapists needing better treatments of individuals with recurrent and habitual self-harming behavior in the case of DBT) and are often explicitly referential of their moral sources (Linehan, for example, makes clear her indebtedness to Zen practice for the conceptual development of DBT). They preserve important roles for indispensable teachers (generally the founders of the movements) and texts such as books, journals, and other publications. They each have developed modest institutions (training conferences, websites, professional organizations) for the fostering and preservation of particular virtues which arise out of the practical-theoretical orientation of the sub-tradition. These institutions, together with the teachers and texts of the tradition, provide fora for theory-laden debate about the goods internal to the tradition. The existence of these sub-traditions within contemporary psychiatry and psychology is, from a MacIntyrean perspective, interesting and encouraging. For these therapeutic “sub-traditions,” however, the question remains: will they own their tradition-constituted identity, or will they, like many of their therapeutic predecessors and contemporaries, inhabit an encyclopedic mode in the effort to justify themselves as “scientific?”
4 The Inescapability of Moral Sources for Psychiatric Diagnosis: How Nosology Displays and Requires Teleology

In the previous chapter I argued, using a typology appropriated from Alasdair MacIntyre in *Three Rival Versions of Moral Enquiry,*¹ that psychiatric diagnosis is best described not in MacIntyre’s “encyclopedic” mode but rather as tradition-constituted discourse, internally derived by mental health professionals (particularly American psychiatrists) in order to serve particular clinical and administrative ends within mental health practice. I argued that such a conception, understood properly, need not undermine the integrity of the *DSM* as a scientific document and in fact strengthens it against genealogical critique.

In this chapter I argue that psychiatric nosology capable of withstanding genealogical critique, particularly when directed to controversial diagnostic categories, requires two sets of conceptual commitments which the *DSM* does not explicitly acknowledge. First, diagnosis adequate to the complexity of clinical practice requires commitment to some form of teleological understanding of the shape of a well-lived human life. The *DSM,* I will argue, cannot both prescind from commitments regarding the nature of human flourishing and serve as a comprehensive guide to the conditions under which psychiatric treatment is appropriate. To the extent that the document presents judgments in politically or morally contested domains, it shows forth particular conceptions of human flourishing because adjudication of what is, and is not, “mental

disorder” in areas of controversy necessarily involves claims about whether the state of affairs in question is, or is not, constitutive of or at least compatible with a flourishing life.

Second, psychiatric nosology capable of withstanding genealogical critique must not presume narrative hegemony over all failures of human flourishing. Psychopathology (or pathology in general), that is, can be recognized as pathology only against some conception of what flourishing looks like; but not all failure of flourishing is best narrated as pathology. Large swaths of human intellectual history, specifically in the history of the “humanities” and the “human sciences,” in some way treat the basic problem of why humans, despite the apparent potential to flourish, so often do not do so. “Vice” is one way of naming this, as is “oppression,” as is “sin.” Because one of the most common genealogical critiques of psychiatry is that it attempts to subsume these other languages to that of “pathology” without appropriate warrant for doing so, a psychiatric nosology answerable to genealogical critique would provide some account of how “pathology” or “mental disorder” can be demarcated from conditions best described in these non-medical languages. But this, as has often been noted, is precisely what the DSM does not do very well. It is here that the “naturalistic” theorists of mental disorder surveyed in chapter 2, particularly Wakefield, are very much on the right track, though they collectively err by presuming that “dysfunction” or “disease” can be described apart from teleological consideration.

At the conclusion of this chapter I turn again to the work of Alasdair MacIntyre, this time in *After Virtue*, to propose one account of why the DSM takes the shape that it
does and, correlative, why it fails in the particular ways that it fails.\textsuperscript{2} Unlike the prior arguments in the chapter, I do not presume this to be an argument of necessity; I do not seek to persuade skeptical readers that MacIntyre’s account \textit{must} be the correct lens by which to interpret the \textit{DSM}. The prior arguments of the chapter, and of the work as a whole, can stand without it. I argue, rather, that MacIntyre in \textit{After Virtue} provides a helpful conceptual account relevant to the \textit{DSM} by correctly predicting the strengths and weaknesses of the document and by providing an account of why the \textit{DSM} is used in the way that it is. Though MacIntyre never treats the \textit{DSM} explicitly in his work, it is reasonable to consider the \textit{DSM} a relic of the culture of late modernity which MacIntyre critically engages in \textit{After Virtue}, in which various attempts to justify morality without reliance on particular sustaining traditions or particular religious-philosophical commitments devolved into an emotivist culture in which “this is good” came to mean little more than “I prefer this.” This devolution, MacIntyre argues, stems from the loss of larger teleological commitments which rendered earlier ethical systems intelligible, specifically by positing a difference between “humans-as-they-happen-to-be” and “humans-as-they-could-be-if-they-realized-their-essential-nature,” with ethics as the science of how one might move from the former to the latter.\textsuperscript{3} This analysis, I argue, accounts both for the appeal of the \textit{DSM} and for its failures. Because, I will argue, overcoming these failures would require the \textit{DSM} project to abandon its late-modern ethical pretensions – a highly unlikely development – the future of the \textit{DSM} project in

\textsuperscript{2} Alasdair MacIntyre, \textit{After Virtue: A Study in Moral Theory, 2\textsuperscript{nd} ed.} (Notre Dame, Ind.: University of Notre Dame Press, 1984).

\textsuperscript{3} MacIntyre, \textit{After Virtue}, 52. I have rendered these quotations in the plural where MacIntyre employs the masculine singular.
providing sufficient answer to genealogical critics is grim. But MacIntyre’s diagnosis does, I will argue, provide resources for moving forward, as I will argue in much more theological detail in Part Two of this work.

4.1 Why Psychiatric Diagnosis Requires Teleological Consideration

The claim that psychiatric diagnosis requires consideration of the shape of a properly lived human life will strike many, including many practicing mental health clinicians, as absurd. Surely, one might object, one can practice good psychiatry (or psychology, or medicine, etc.) without either clinician or patient being required to take specifically philosophical or religious stands. In order to ward off misunderstanding, it may be helpful to know what I am not arguing. First, I am not arguing either that clinicians or patients possess, in many cases, well-worked-out accounts of the flourishing human life. They are each more likely to be fixated on more immediate practical ends, such as relief of the suffering of the patient. Second, I am not arguing that clinicians must conjure an explicit account of the good life with each patient contact, or must have such an explicit account waiting in the wings if pressed to reveal it. Most clinicians in everyday practice, I believe, have no such account at hand; and most clinicians can seem to get along just fine in most clinical situations without one. What I am arguing, rather, is that nearly all judgments about the presence or absence of psychopathology involve judgments about whether a person’s thought, emotion, and behavior constitute a good fit with the person’s environment and social world, and that judgments of fit require some conception of appropriate human function, of how a reasonably “functional” person,
within a range, would respond to his or her environment. But these are not judgments which can be made apart from commitments, either implicit or explicit, of what it means for humans to function well, or to flourish: psychopathological judgments show these commitments clearly by naming their outer limits. These commitments, acknowledged or not, are inextricably moral commitments; insofar as clinicians and patients hide these judgments of fittingness behind a façade of scientific or clinical neutrality, they remain vulnerable to modern-day antipsychiatry critique.

Such a claim may seem presumptuous given the sophisticated and detailed attempts by the “naturalistic” theorists of mental disorder mentioned in Chapter 2, particularly Jerome Wakefield, to rescue “mental disorder” from antipsychiatry critique by grounding it partially in an account of biological part-dysfunction which ostensibly does not make reference to the character of human flourishing beyond function-as-evolutionary-“design.” Although I have much respect for Wakefield’s rigorous mode of analysis, I wish to argue that Wakefield does not succeed in freeing psychiatric diagnostic judgments from the need for broader accounts of human flourishing. This is best illustrated, in my view, by starting with three brief vignettes which reflect how diagnostic judgments actually happen in “on the ground” psychiatric practice.4

**Vignette 1:** Jay Carpenter is a forty-four year old man who presents to a psychiatrist on referral from his primary care physician, who he called with concern that he was “going crazy.” He describes himself as an “introvert” and says that although he

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4 All of these names and cases are fictional but are intended as composite sketches of a large number of clinical presentations from my own practice. Any of these cases would, I believe, be familiar ground for any practicing psychiatrist.
loves and excels at his work as a computer programmer (“I have very high standards for myself”), he has never been a “people person” because he is constantly afraid of being criticized. Though his marriage of ten years (to a fellow employee at his company) has been satisfying, he has few other friends and becomes quickly intimidated in social situations. Recently his anxiety has “skyrocketed” as his boss (and unit leader) left the company abruptly and Jay, the most senior programmer in the unit, has been forced to assume many of his boss’ former responsibilities, which includes a significant amount of public speaking and networking with higher-level administrators. Although he knows that he should not be so anxious, he says that this exposure “terrifies me” and he wonders if a medication can help him better handle the “stress” and “anxiety” of being on his job.

Vignette 2: Beth Morris is a twenty-five year old woman who presents to a psychiatrist for a first visit requesting a “refill” of her antidepressant medication bupropion (trade name Wellbutrin XL®), stating that her previous psychiatrist was moving out of state and had referred her for further care. Although she says that she is taking the medication for “chronic depression,” a careful diagnostic interview reveals that she has never had what the DSM would categorize as a major depressive episode; she does, however, meet the criteria for the related category of Dysthymic Disorder (300.4), characterized by at least two years of depressed mood for most of the day, more days than not, along with (in her case) low energy and low self-esteem. She says that these symptoms date at least to the divorce of her parents when she was a sophomore in high school but seem to remit partially when she takes bupropion, which she was first prescribed six years prior by a student health physician at her university when she had
presented with complaint of feeling depressed and stressed after a relationship ended and her coursework seemed overwhelming. She says that bupropion “helps keep me energetic” and that she also likes it because it helps her control her weight.

Vignette 3: Rob Dawkins is a twenty-one-year-old graduate student in neurobiology brought to a psychiatric emergency service by his very worried father, who drove five hours to pick him up after a roommate called to report that Rob was “not right.” Rob is irritated and indignant at being confined in a locked setting in the emergency department and says, quickly and repeatedly, that he is fine, that everything is fine, that he is “better and more productive than I’ve ever been,” and needs to be discharged so that he can go home to work on a novel which he started writing the week before. His father says that the roommate reports that Rob has not slept in 3-4 nights and has acted “like a tornado” for over a week. Rob’s father says that Rob, who loves science but had never previously shown much interest in the literary arts, had decided to write “a great novel” and, in preparation, had mail-ordered a large number of novels, which have started to arrive in large packages at his apartment. Rob’s father is worried in part because Rob’s mother, from whom his father is now divorced, has been in longstanding treatment for bipolar disorder.

Can these three individuals rightly be described as “mentally disordered,” with the acknowledgement that a label of this sort would quite likely serve the function of legitimizing and enabling the employment of psychiatric medication and/or other technologies? On a superficial level, it is clear that all manifest “mental disorder” because they all meet DSM-IV criteria for various mental disorders (Jay Carpenter for
Social Phobia and, likely, Avoidant Personality Disorder; Beth Morris for Dysthymic Disorder; and Rob Dawkins for an acute manic episode which is a likely herald of Bipolar I Disorder). But there are deep conceptual/theoretical differences among them, and I suspect that different readers of this text will come to different conclusions (which I am hesitant to override with immediate interpretation) regarding the appropriateness of a “mental disorder” diagnosis and of technological intervention for each of them. Rob Dawkins meets “textbook” criteria for a condition which is widely accepted as a “real” mental illness in contemporary culture, and yet, importantly, he is not distressed and does not view himself as disordered, and there are still some modern-day Szaszians and Laingians who would deny that his condition is best described with medical/pathological language. Jay Carpenter is acutely distressed and is seeking medical help, but the diagnosis which would contextualize “treatment” with anxiolytic medication (or psychotherapy, which is less controversial in this context as it does not rely as heavily on the medical model) has been heavily criticized as “medicalizing shyness” and, worse, as providing a convenient pretense for the mass-marketing of anxiolytic medications by the pharmaceutical industry. Perhaps, critics might say, Jay Carpenter is just not cut out for leadership positions which demand a high public profile; being shy may be professionally unfortunate for him, but it hardly demands a medical explanation. Besides, neo-Foucauldians might say, is it not his company, rather than him, which is driving him into “therapy?” Likewise, Beth Morris has clearly embraced the medical model as a contextualizing narrative for her chronic distress, and understands herself as someone who requires longstanding treatment with antidepressant medication in order to function
properly. But low self-esteem, low energy, and chronic sadness in the context of life difficulties and acute loss would likely not have been described medically either in prior eras of American-European culture or in other contemporary cultural settings; why, critics might ask, should it be in ours? And what are we to make, after all, of her preference for bupropion on the ground that it improves her energy level and helps prevent weight gain?

Simply invoking DSM-IV to justify a label of “mental disorder” does nothing to answer these critiques, which might or might not be on the mind of either patient or clinician (or family members) in any of these three settings. The critiques apply even in a “smooth” encounter in which patient and clinician agree about the appropriateness of a particular description and the utility of a particular treatment. They also apply if the clinician and the patient disagree about whether the patient’s situation is best described as “mental disorder” legitimating medical treatment and have to work collaboratively (or not) to achieve a mutually agreeable description. They apply, in fact, whenever the

5 Clinical disagreement may take a number of forms. If the patient desires diagnosis and medication, the psychiatrist may choose, in the interest of keeping a timely schedule, pleasing the patient, running a “psychopharmacology” practice, or some other reason, not to present his or her own concerns and may simply assign a diagnosis and write a prescription. Alternatively and rarely, at the risk of alienating the patient, a psychiatrist may lecture the patient and refuse to assign a diagnosis or to write a prescription. More commonly, though, when faced with a discrepant interpretation of a situation, a physician and/or psychiatrist will engage the patient more deeply and, in an inseparable interchange of collaboration and persuasion, will attempt to establish a mutually agreeable description. Although the psychiatrist may come to a different view in the process of this exchange, he or she will usually be looking for the patient to convert to the understanding of the psychiatrist. Such a process, even if it results in practical agreement between clinician and patient, does not rescue the question from conceptual critique. If this process fails, the patient and psychiatrist may agree to end the relationship or, in the case of a patient who refuses treatment which is recommended, the psychiatrist may in some cases enact involuntary commitment and/or forced-treatment laws to coerce the patient into a particular form of therapy (e.g., forced short-term hospitalization).

Psychiatrists often do not like to think of themselves as engaging in persuasion since they have been warned against physician paternalism, but in fact psychiatrists are often very skilled at persuasion, perhaps especially when they do not name what they are doing as “persuasion.” In my view the appropriate
status of a state of affairs as “mental disorder” is left to the private judgment of either patient or clinician (or other individuals, such as Rob Dawkins’ father) without reference to a broader conceptual account of what constitutes “disorder.” Without such a nonindividualistic standard, diagnostic decisions remain ever-vulnerable to deconstructive, Foucauldian critique that the use of diagnostic language functions to discipline the patient into various regimes of power – of the psychiatrist, of the state, of the pharmaceutical industry, of the consumer culture, of the market economy, and on and on. To what resource, then, can either clinician or patient turn in order to provide a satisfactory defense against these critiques?

One solution would be to turn to the consensual standard of the culture and/or the internal standard of the psychiatric professional guild regarding the appropriate use of psychiatric diagnostic language. But this will not help in the three cases listed above since the DSM is both the closest approximation of a cultural consensus regarding psychiatric diagnosis and, at the same time, the internal standard of psychiatry – and these patients clearly satisfy the DSM criteria for particular mental disorders. The question at stake is not whether these patients meet the commonly accepted standards for diagnosis (they do) but, rather, whether this commonly accepted standard is itself appropriate. Satisfying the DSM, in other words, in no way rescues the process from conceptual critique.

stance toward psychiatric persuasion (and also coercion) is not to deny either its reality or its necessity but rather quite the opposite, to transparently name it for what it is and therefore to be prepared to defend it as a moral act which is intelligible only in a particular communal form of life. Such transparency would, in my view, do more to discipline psychiatric persuasion than a thousand articles defending psychiatric patient “autonomy.”
This is, of course, not a new point, and the architects of the modern *DSM*, particularly Robert Spitzer, were very aware, as described in some detail in Chapter 2, that the modern *DSM* requires internal safeguard against uses which would bring psychiatry and psychiatric diagnosis into public disgrace as happened during the awkward debates over the diagnostic status of homosexuality in the 1970s. These internal safeguards take two principal forms in the *DSM-IV-TR*, and the clinicians and patients described above could make reference to either. There are first the “distress/impairment” criteria built into many individual criteria sets in the *DSM*. The *DSM-IV-TR* criteria for Dysthymic Disorder, for example, require that “the symptoms [of the condition] cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.”*6* For individuals with Social Phobia, “the avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.”*7* Individuals diagnosed with an acute manic episode must show a mood disturbance “sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or [in which] there are psychotic features.”*8* But it is easy to see that these criteria are not likely to be very helpful in rescuing the judgments in these individual cases from conceptual critique

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*7* Ibid., 456.

*8* Ibid., 362.
because, as has been noted elsewhere, the characterization of the distress involved as “significant” cannot be used as a criterion for “caseness” of mental disorder because the “significance” of the distress is precisely what is being put to the question. Who, in other words, is the arbiter of what constitutes “significant?”

The distress/impairment clauses in the DSM-IV criteria sets do not, of course, mention only distress; they also make reference to impairment or dysfunction. It is plausible, then, that the clinicians or patients mentioned above could attempt to meet the conceptual critique head-on, as Wakefield attempts to do, by demonstrating the presence of a dysfunction. They might refer not only to the individual criteria sets, but also to the DSM-IV definition of “mental disorder” which, though alluded to in Chapter 2, is worth citing here:

In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not merely be an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.

One of the confusing things about this definition, leading to easy misinterpretation, is the equivocal use of the concept of function. “Dysfunction” and “function” are used in two

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10 DSM-IV-TR, xxx-xxxi.
quite separable ways in this paragraph. The penultimate sentence stipulates that mental disorders, however caused, must be considered a manifestation of some sort of dysfunction in the individual. This “dysfunction in” concept is the working concept of “dysfunction” in the writings of Christopher Boorse, Donald Klein,11 and particularly Jerome Wakefield. But it is not the concept of dysfunction which carries the day in the DSM-IV criteria sets. This quite different concept of dysfunction—named not as “dysfunction” but as “impairment in . . . functioning”—is rather dysfunction of the individual in the various roles and tasks which the person considers constitutive of his/her identity. One can rightly (by DSM-IV standards) diagnose Dysthymic Disorder not by observing dysfunction in the individual (though something like this may well be present) but by observing dysfunction (or “impairment in function,” which is the same thing) of the individual in various important roles and tasks. But what this means is that even by standards internal to the DSM, a clinician cannot make a responsible diagnosis only by considering an individual in isolation. Rather, the clinician must understand both the person’s social/cultural world and, importantly, render a judgment about what it would look like for the patient to function appropriately within that social/cultural world. Only then, with some (at least implicit) boundary of “normality” in place, could the clinician discern what it might mean for the patient to be “impaired.”

Judgments about “impairment in function” are not clear-cut, because what one person understands as “impairment” another may understand as unreasonable expectation. I am almost six feet five inches tall, but I never played college basketball, or

even varsity high school basketball, because I can’t jump or shoot well. That this is the case is perhaps unfortunate, but it is hardly the manifestation of pathology. Nor would it necessarily have been pathology if I had not demonstrated the academic and intellectual aptitude required to pursue medical training or graduate work in theology. Having completed psychiatric training, however, were I suddenly to become unable to function as an effective psychiatrist, others might justifiably wonder about the presence of some sort of pathology. If it turned out that this inability to function were temporally related to the death of a beloved pet, others would (no doubt with relief) no longer worry as much about pathology; but if I did not return to appropriate function within a relatively short time, they would perhaps begin to worry again. But all of these judgments entail some vision of the kind of function which would be appropriate or fitting in any given situation; “pathology” or “disorder” is one (but not the only) way to describe outer limits of appropriate human function in any given situation.

“Naturalistic” theorists of mental disorder would resist the argument that diagnosis requires judgments about “dysfunction of.” Advocates of Wakefield’s “harmful dysfunction” model would maintain that the “dysfunction” necessary for mental disorder is always “dysfunction in” the mind or body and not “dysfunction of” the person in a particular context, as I am suggesting. One might observe “dysfunction of,” but one would assign disorder-status only if one could thereby infer the presence of “dysfunction in.” I do not entirely disagree with this, but this account runs into formidable epistemological obstacles. If, that is, what is observed is “dysfunction of” rather than “dysfunction in,” and there is no clear understanding of what constitutes “dysfunction in”
without reference to “dysfunction of;” then it is very unclear on Wakefield’s terms why
the inference of “dysfunction in” is warranted. In their attempt to distinguish “normal
sadness” from “depressive disorders” on the basis of the harmful dysfunction model,
Horwitz and Wakefield argue that “only in the light of some account, however
provisional or sketchy, of how loss response mechanisms are designed to work and thus
of their normal functioning do we have grounds for calling some responses to loss
disordered;” judgments of disorder are therefore context-specific.¹² They argue that
normal sadness is characterized by emergence in response to specific environmental
triggers, proportionality in intensity to the provoking loss, and remission when the loss
ends and/or when “natural coping mechanisms allow an individual to adjust to the new
circumstances and return to psychological and social equilibrium.”¹³ Sadness which does
not follow this pattern shows, in their view, dysfunction of evolutionarily acquired loss-
response mechanisms. They concede, however, that the exact nature of this dysfunction
is unknown:

Important questions arise because we do not yet know precisely which internal
mechanisms produce loss responses or what these mechanisms are actually like. If the mechanisms are inferred to exist but their specific nature is unknown, how
can one tell that normal loss responses are indeed part of our biological heritage?
And, without knowing the mechanisms, how can we tell what is normal and what
is disordered? . . . The fact is that, although the distinction cannot yet be
determined precisely, in the history of medicine and biology scientists have
routinely drawn such inferences about normal and disordered functioning from
circumstantial evidence without knowing the underlying mechanisms. So, for
example, Hippocrates knew that blindness and paralysis are disorders and that
there are mechanisms that are designed to allow human beings to see via their
eyes and move via muscular effort, but he knew little of the mechanisms

¹³ Ibid., 16.
themselves and thus little of the specific causes of most cases of blindness and paralysis (other than gross injury). It took thousands of years to figure out those mechanisms, but during that time it was universally understood from circumstantial evidence that sight and movement are parts of human biological design. It is no different in principle with human mental capacities that are part of our biological nature, such as basic emotions.\textsuperscript{14}

There are several problems, though, with this argument. First, it is circular because it uses the existence of the “mechanisms” of sight and movement as evidence for the existence of analogically related “loss response mechanisms,” when what is at question is precisely whether such an analogical extension of the concept of “mechanism” is appropriate when applied to the emotional responses of a person to particular situations. (That is, the authors metaphorically apply the mechanical language of “mechanism” to mental phenomena and then, when the existence and nature of these mental mechanisms is called into question, argue that the existence of mental mechanisms can be validly inferred from the presence of material mechanisms.) Is the supposition that “mechanism” underlies all physical and mental phenomena an observation or an \textit{a priori} assumption used to interpret particular observations? Second, the clinical experience of Freud and the recognition of the phenomena of “conversion disorder,” in which neurological symptoms appear without discernible physiological correlates, should make clear that one can \textit{not} always infer from the presence of blindness or paralysis a dysfunction of any particular “mechanism.” That one is blind or paralyzed does not mean necessarily the eye or nerves are damaged; something else could be going on. My point is not to argue against the existence of the kind of biological or mental apparati which would render conception of “dysfunction in” intelligible, but rather to point out that in the absence of a

\textsuperscript{14} Ibid.
clear description of the mechanisms themselves, inferences of “dysfunction in” are
to be bound, retrospective interpretations made on the basis of judgments about the
presence of “dysfunction of.” “Dysfunction of,” not “dysfunction in,” is the driving force
of dysfunction-judgments in clinical psychiatry.

Other naturalistic theorists of mental disorder, like Boorse, would object that judgments about dysfunction are primarily statistical; the fitting function in a particular
situation is the species-typical one, that which would be expected of a non-deviant
member of the “reference class,” which Boorse specifies as “an age group of a sex of a
species.” Indeed, some forms of mental disorder such as mental retardation are
expressly defined by deviation from a population mean (on standard intelligence tests).
But this will not work in everyday clinical decision-making, and not just because of the
frequently observed problems of boundary-marking (why was a Wechsler IQ score of 70
chosen to mark the cutoff for “mental retardation”? What is so special about a two-
standard-deviation variance from the mean?) and of the existence of non-pathological
deviation (those who are two standard deviations above the intelligence mean are not
considered disordered for that reason alone). Rather, practically, the kind of population
data necessary for meaningful dimensional measurement (as one obtains on the Wechsler
IQ test) is just not available to clinicians and patients making on-the-ground judgments

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15 More specifically, for Boorse, “a normal function of a part or process within members of the reference
class is a statistically typical contribution by it to their individual survival and reproduction.” Boorse, “A

16 “Mental retardation” is the DSM-IV term despite its widespread rejection by the disability community, so I
will use it here. The DSM-5 equivalent will likely be “intellectual disability.”

17 Derek Bolton, What is Mental Disorder? An Essay in Philosophy, Science, and Values (New York: Oxford
University Press, 2008).
about the appropriateness of function. Judgments about whether I am functioning adequately as a psychiatrist, or whether Beth Morris is functioning adequately in her various roles, are made heuristically at best.

The efforts of the “naturalistic” theorists of mental disorder to define some component of “mental disorder” which does not depend on evaluative consideration are not, then, successful. But there is yet another reason why this is so. The invocation of the concept of function in the DSM criteria is inescapably teleological and not statistical only. Though a defense of a philosophical account of function is beyond the scope of this chapter, it is fair to say that in ordinary language, function implies the presence of an end, goal, or product toward which the function is oriented; were this end removed, the function would lose not only its end but also its conceptual status as a function (barring the presence of other ends). To speak, then, of an individual’s “areas of functioning” is to conceptualize the individual as oriented toward particular ends (interpersonal, occupational, academic, and so on), which is to say that any description of the “function of” an individual is already a teleological description. The operative question then becomes not “are we to understand this diagnostic decision teleologically or nonteleologically?” but, rather, “what sort of telos are we assuming for this individual which can make decisions about disability and dysfunction intelligible?”

The kind of telos shown by such judgments will differ according to the context of the particular diagnostic decision. Diagnostic judgments in psychiatry will seldom if ever require an account of eudaimonic perfection. One does not, to make diagnostic decisions, need to know the shape of the highest instantiation of human flourishing; one needs only
to commit to some outer limit of flourishing past which a description of disorder may be justified. But the specificity of this commitment will vary in different clinical situations.

In the case of Rob Dawkins, one needs only to know that individuals who share his experience and who are rightly named “manic-depressive” or “bipolar,” despite their lack of distress while manic, will over time, unless treated, act, think, and feel in ways that are deeply inconsistent with a fully flourishing life; one may judge Rob “disordered” without showing commitment to any specific version of human flourishing beyond that. But somewhat more specific commitments are needed for Jay Carpenter and Beth Morris. In each of these cases the patient has presented in distress or with self-perceived impairment in function or both, and the task of the clinician is to judge, in collaboration with the patient, whether the patient’s current state is, in fact, inconsistent with a flourishing life and, if so, whether medical-psychiatric description is a truthful way to name that inconsistency (which we will consider further in the next section). This is also the case with other socially contested diagnostic categories such as attention-deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD; see chapter 5), and the various personality disorders. And it is perhaps most clearly demonstrated in the category of “sexual and gender identity disorders.” Is a man mentally disordered who presents to a psychiatrist with distress over at least six months of recurrent, intense, sexually arousing fantasies of intercourse with female peers? What about a man who presents with similar complaints, except that the fantasies are directed toward prepubescent children? Or what if they are directed toward male peers? Or what if the fantasies involve exposing his genitals to strangers, or rubbing his genitals against a nonconsenting person? Or what if
an adult man says that he is a “woman in a man’s body” and desires to live in society as a woman but is distressed by these thoughts? Is the appropriate diagnostic/therapeutic course to help the patient accept and even welcome these desires and to act on them in a controlled and hopefully harm-reducing way? Or is it to see the desires as per se disordered and to help the patient to resist them successfully? We may imagine, for the sake of argument, that the man’s absolute level of distress is identical in all of these cases, and yet individual mental health clinicians, following DSM-IV and their own clinical judgment, would likely assign disorder-diagnoses in some of these situations but not in others, reflecting the clinicians’ commitments regarding the outer limits of the types of sexual behavior consistent with the well-lived human life.\textsuperscript{18}

Psychiatric diagnosis is therefore intrinsically teleological; though it may not require a fully-fleshed-out account of the highest forms of flourishing, it at least requires a commitment to some answer of the question, “is this individual functioning in his or her particular context in the way that healthy human beings function?” Such an answer renders an “aboutness” to life which renders judgments about function, and therefore about pathology, intelligible.

\textsuperscript{18} Diagnoses of the sexual and gender identity disorders are so tied to these commitments in contemporary psychiatry that the degree of patient distress is often nearly irrelevant. DSM-IV-TR (2000) revised the DSM-IV (1994) criteria for pedophilia to clarify that one could be assigned a disorder diagnosis even in the absence of distress or clearly evident occupational or social impairment. On the other hand, the American Psychiatric Association, in a 1998 position statement, discouraged psychiatrists from providing therapies intended to change one’s sexual orientation even if the individual presented in distress about same-sex attraction. American Psychiatric Association, “Psychiatric Treatment and Sexual Orientation,” http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/199820.aspx (accessed March 18, 2011). Of note the American Psychological Association, in a recent extensive report, offered more nuanced guidance for psychologists. See APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation (Washington, D.C.: American Psychological Association, 2009).
4.2 Why Psychiatric Diagnosis Requires Demarcation of the Medical from the Non-Medical

Though “mental disorder” always implies some lack of human flourishing, it is by no means the case either that the lack of human flourishing necessarily implies “mental disorder” or that the absence of “mental disorder” necessarily implies the presence of human flourishing. This is because there are many other obstacles to human flourishing which are not, in ordinary language, denoted by “mental disorder.” This seems, on first glance, so intuitively obvious as to need no further argument. If I plagiarize an academic paper, or cheat on my tax return, or plot to harm an innocent neighbor, I am acting in a way which is deeply inconsistent with nearly any seriously proposed conception of human flourishing – but I cannot thereby claim, for those reasons alone, to be “mentally disordered.” However, demarcating states of affairs which are appropriately described as “mental disorder” or psychopathology from states of affairs which are appropriately described using other conceptual models (e.g., that of virtue and vice, or of sin and righteousness, or of stress and adaptation) has proven notoriously difficult. Most of the modern-day antipsychiatry critiques, in fact, center on some variant of the charge that the mental health professions have inappropriately labeled particular states of affairs as “medical” or “clinical” conditions when in fact they are better described in other systems of language. Complicated questions abound. Is “antisocial personality disorder” a medical, sociological, or moral description, or all of the above? Does “bipolar disorder” excuse its bearers from moral responsibility from their actions while “manic” or “hypomaniac?” If so, in what way? Does “borderline personality disorder” excuse from moral responsibility in the same way? Should a person with “pedophilia” who rapes a
child be granted some leniency by the criminal justice system by virtue of bearing that
diagnosis? What about a person with “post-traumatic stress disorder” or “mental
retardation” who demonstrates the same behavior? Should dangerous overuse of alcohol
be understood as disease, vice, or sin – or all of the above?

Three overlapping solutions to the problem of demarcation, each surveyed in
some detail in Chapter 2, have emerged within contemporary philosophy-of-psychiatry
debates. “Naturalistic” thinkers, led by Christopher Boorse and Jerome Wakefield, have
stressed the need for a value-free account of “disease” or “dysfunction” capable of
demarcating such conditions from all other failures of flourishing. Such accounts
construe disease or dysfunction as occurring within the individual and manifested as
failure of function, whether as deviation from species-typical norms (Boorse) or as failure
of a physical or mental mechanism to function as it was designed to do by the
evolutionary process (Wakefield). “Values-based” thinkers hold, to the contrary, that
disorder-judgments are unintelligible apart from the particular goals of the person, the
cultural context, and the evaluative judgment of the clinician. Diagnostic judgments are
therefore value driven “all the way down,” and clinicians ought to be transparent about
these guiding values. Such a claim, though, means that the pathology/nonpathology
boundary cannot coincide (pace the naturalistic accounts) with a “fact/value” boundary,
and so one must rely on different criteria to demarcate pathological from nonpathological
failure of flourishing. Different thinkers whom I have characterized as “values-based”
take different approaches to this question. Fulford (1989) construes mental illness as
“failure of ‘ordinary’ doing in the apparent absence of obstruction and/or opposition;”
that is, mental illness is a condition which thwarts the intentional agency of the individual when no external barrier seems to do so. Sadler (1995), however, aligns more closely with the third category of thinkers whom I have loosely labeled “pragmatist.” For Sadler, as (in different ways) for Brendel, Ghaemi, McHugh and Slavney, and Bolton, a state of affairs is best described as “mental disorder” when psychiatric intervention would prove helpful in ameliorating it; in Bolton’s words, the medical is “defined fundamentally by a distinctive kind of response to problems, rather than by a distinctive kind of problem.”

The pragmatist model, however, concedes too much. In its frank admission that “mental disorder” cannot be sharply distinguished from other failures of flourishing and that the choice of medical language to describe the condition should therefore be based on the likely results of doing so, the pragmatists successfully sidestep traditional antipsychiatry assaults on the supposed “objective” and “scientific” nature of psychiatric diagnosis, but in so doing lose the ability to withstand assertions that psychiatric diagnosis is a thinly veiled masquerade for psychiatric power. If, in other words, clinical truth is equated with therapeutic usefulness, the question, “is ‘mental disorder’ the best way to describe this state of affairs, even when technological intervention is effective?”

23 Derek Bolton, What Is Mental Disorder?
24 Ibid., 194.
becomes meaningless. A Foucauldian critic would readily agree that psychiatric diagnosis is powerfully reinforced by the “effectiveness” of the treatments it legitimizes, but would see this not as proof of its validity but rather as proof of its disciplinary power. Of course attention-deficit hyperactivity disorder (ADHD) is a popular diagnosis in college student health clinics, such a critic would say, because stimulants like methylphenidate (Ritalin ®) and amphetamine salts (Adderall ®) will transiently improve concentration and focus (and therefore academic performance) in most people who take it. Of course post-traumatic stress disorder (PTSD) is an exceedingly common diagnosis among American combat veterans, because such a diagnosis not only provides a contextualizing narrative for dysfunctional behavior after return to civilian life but also serves as the gateway to disability benefits – and as a convenient portal into the sick role for potential critics of military action. I do not wish to argue that either of these critiques is true (I don’t believe that matters are that simple), but rather to point out that a diagnostic judgment which a patient and/or clinician finds pragmatically helpful may appear coercive or dehumanizing to someone with a different perspective. Sadler (2005), at one point in his long and rich analysis of psychiatric diagnosis, argues that the DSM should exist not to aid clinical practice but “to aid the mentally ill.” Of course. But (as Sadler might agree) before we ask whether a particular diagnosis will aid the mentally ill, we must ask whether the mentally ill are appropriately described as “mentally ill,” lest diagnosis become a subtle means of coercion. But this can only be determined from a particular perspective and within a particular evaluative context, and most pragmatic

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25 Sadler, Values and Psychiatric Diagnosis, 439.
accounts have difficulty accounting for the basic question of who should decide what constitutes “benefit.”

The various “naturalistic” thinkers, recognizing the pitfalls of diagnostic pragmatism,\(^\text{26}\) are on the right track in seeking to establish particular public criteria for “disease,” “dysfunction” and/or “disorder” which do not rely exclusively on the subjective interpretation of patient or clinician. Such theories have the virtue of successfully excluding some failures of flourishing from the medical model even if the “treatments” enabled by such a model were to result in some subjective benefit. But neither Wakefield’s “harmful dysfunction” analysis nor Boorse’s “biostatistical theory,” as argued in the last section, provide accounts of “dysfunction in” a person which do not depend on quite different judgments about “dysfunction of” the person in various social and environmental contexts.\(^\text{27}\)

The inadequacy of the most influential naturalistic models, however, does not mean that one must jettison the naturalistic approach to demarcation \textit{tout court} in favor of a “values-based” approach. The “values-based” theorists are correct, as previously argued, that psychiatric diagnosis is unintelligible apart from commitments to particular conceptions of human flourishing, even if the unfortunate dominance of “value” language in their writing tends to perpetuate the fact/value dichotomy that their work in many ways

\(^{26}\) cf. Horwitz and Wakefield, \textit{The Loss of Sadness}.

\(^{27}\) In addition to this, it is not clear that evolutionary biology can bear the teleological weight which Wakefield places upon it. As others have pointed out, knowledge of evolutionary history and selection pressures are sufficiently sketchy that inferences about evolutionary “design” are often conjectural and context-dependent. In addition, it is unclear, on Wakefield’s account, why natural selection deserves the teleological assent which Wakefield assumes for it. Why should humans care about survival and reproduction more than about other goods? Would the kind of devotion to a god which leads to the loss of one’s life be construed as “harmful dysfunction” for Wakefield?
seeks to undermine. But recognizing the necessity of teleological commitments for psychiatric diagnosis does not negate the possibility of “naturalistic” demarcation, as if one could no longer speak meaningfully of “natural” dysfunction if one recognizes the prior necessity of these commitments. Rather, such commitments make coherent speech about the “natural” possible. The “natural” is a category which makes sense only in the context of broader ontological and teleological commitments.

Naturalistic theories of disease and dysfunction have, more often than not, taken the form of what we might call “bottom-up” accounts, in which “disease” or “dysfunction” are understood independently of and prior to higher-order claims about morality, social deviance, and so on. In Wakefield’s model, for example, one establishes the presence of “dysfunction” on evolutionary biological grounds and then applies higher-level analysis to determine whether the dysfunction is harmful and, therefore, “disorder.” But this doesn’t work for Wakefield because, as demonstrated above, lower order “dysfunction in” is practically unknowable apart from higher-order “dysfunction of.” Wakefield needs the contextual judgment of “dysfunction of” in order to make sense of the naturalistic concept of “dysfunction in.”

Bottom-up naturalistic approaches can never adequately address the problem of demarcation. If, that is, one starts with some bare conception of “nature” or “the body” and asks whether a particular individual’s distress is reflected somehow in “the body,” the answer will, more often than not, be “yes.” One might, for example, ask whether a compulsive user of alcohol manifests this compulsion in the body and conclude that, yes, this is the case (though demonstrating that this constitutes “dysfunction in” the body is a
more complex matter). But if one then asks how this bodily state of affairs relates to higher-order concepts such as moral agency, one will be left with incommensurable languages and no way to arbitrate between them. If, though, one starts with a higher-order concept such as moral agency and understands dysfunction of the body (or of correlative concepts such as the psyche or the personality) in the context of moral agency, then questions about whether alcohol dependence should be understood as “bodily dysfunction” become, not simple, but at least intelligible. Analogous to Fulford’s categorization of “disease” as a subclass of “illness,” and not vice versa, “natural” categories like “body” and “personality” take their place within higher-order understandings of personhood and personal agency.28 For successful demarcation of “mental disorder” or psychopathology from other deficits in human flourishing, therefore, one needs not an account of the “natural” alone but an account of the “natural” in the context of higher-order ends; one needs not an account of the “body” (or “psyche,” or “personality”) alone but an account of the body in the context of the moral agency of the person. But this means that delineating the “natural” is at least a philosophical, and perhaps even a theological, task.

This way of putting it is, of course, not a solution to the problem of demarcation, but a proposal for the form that any successful solution will take. One still needs, of

28 The example of my own writing may help to make this clear. Earlier in the day, when I was deeply immersed in writing the initial draft of this chapter and not excessively fatigued, I was so wrapped up in the moral project of writing that I was scarcely mindful of my body. As I write these sentences late in the evening, I find it much more difficult to write coherently, and I wonder why this is the case. I know that certain nonvirtuous moral actions on my part -- repeatedly checking newspaper sites on the internet, for example -- can make it more difficult for me to write coherently, but none of these seem to apply at present. But I am increasingly aware of my body, of the slight ache in my back and shoulders, of the heaviness in my eyelids, of the dull disconnection of thought which I associate with sleep deprivation. My body therefore becomes present to me as a means by which to understand my late-night impairment in agency.
course, an actual model of how the natural, or the body, relates to higher-order models of discourse.\textsuperscript{29} Although I will attempt to outline the parameters of a Thomistic model in Part Two of this work, I will not push the analysis further here, except to point out that no integrated model which hinges on particular metaphysical and even theological commitments will, in our culture, command universal assent. The problem still remains, then: \textit{who decides} how to demarcate “mental disorder” from other failures of human flourishing? This is a nearly intractable problem for the \textit{DSM} and for psychiatric diagnosis in general; for one model of \textit{why} this is so intractable, we turn to Alasdair MacIntyre and his work in \textit{After Virtue}.

4.3 Why the Enlightenment Project of Describing Psychopathology Had to Fail (and How to Move Forward)

MacIntyre’s \textit{After Virtue} is a book about moral theory rather than about psychiatry or medicine – or so it seems. The basic argument of the first half of the book (on which I will focus here) is familiar ground. Imagine a possible future, MacIntyre writes, in which a sociopolitical revolution systematically destroys scientific texts and laboratories and a Know-Nothing political movement abolishes the teaching and practice of science. A later generation might try to revive “science” and might even use various scientific-sounding terms, but without an understanding of the coherent structure of science as it was, such language would be increasingly arbitrary and gravely disordered.\textsuperscript{30} Such, argues MacIntyre, is the state of moral theory in late modernity; both moral

\textsuperscript{29} One can imagine, of course, a framework which denies the reality of either the “natural” or the “body.” But I will not engage this here.

\textsuperscript{30} MacIntyre, \textit{After Virtue}, 1-2.
philosophers and the general public continue to use moral words such as “good,” but such expressions are “fragments of a conceptual scheme, part of which now lack those contexts from which their significance derived.”\textsuperscript{31} MacIntyre finds evidence for this fragmentation in the limitlessness and intractability of contemporary moral/political debate, in which moral disagreement is notable only for its shrillness. This apparent incommensurability of rival moral views has led to the embrace of some variant of emotivism, the general conception (attributed by MacIntyre not to Carnap and Ayer but to G. E. Moore and the Bloomsbury culture) that “all moral judgments are nothing but expressions of preference, expressions of attitude or feeling, insofar as they are moral or evaluative in character.”\textsuperscript{32} Such characterization of moral argument is so pervasive that we live in an “emotivist culture.”\textsuperscript{33}

This emotivist moral philosophy, for MacIntyre, is only intelligible within a particular sociology, one which “[obliterates] any genuine distinction between manipulative and non-manipulative social relations.”\textsuperscript{34} That is to say that if there is no meaningful distinction between “normative rationality” and “the sociology and psychology of persuasion,” which within emotivism there is not, then “the sole reality of distinctively moral discourse is the attempt of one will to align the attitudes, feelings, preferences, and choices of another with its own. Others are always means, never ends.”\textsuperscript{35} This kind of culture gives rise not only to bureaucratic rationality, which subsists in persuasion and manipulation, but also to three “characters” who serve as

\textsuperscript{31} Ibid., 2.  
\textsuperscript{32} Ibid., 12.  
\textsuperscript{33} Ibid., 22.  
\textsuperscript{34} Ibid., 23.  
\textsuperscript{35} Ibid., 24.
“moral representatives of their culture.”36 The “rich aesthete” is one who “with a plethora of means restlessly searches for ends on which he can employ them.”37 The “manager,” on the contrary, works within an organization to direct scarce resources to predetermined ends; treating the ends of the organization as outside his or her scope, the manager serves as an expert in matching means to ends in the most efficient manner. The “therapist,” MacIntyre’s third character, resembles the manager in treating ends as given, outside his or her scope:

[The therapist’s] concern also is with technique, with effectiveness in transforming neurotic symptoms into directed energy, maladjusted individuals into well-adjusted ones. Neither manager nor therapist, in their roles as manager and therapist, do or are able to engage in moral debate. They are seen by themselves, and by those who see them with the same eyes as their own, as uncontested figures, who purport to restrict themselves to the realms in which rational agreement is possible – that is, of course from their point of view to the realm of fact, the realm of means, the realm of measurable effectiveness.38

MacIntyre’s characters are intended as types, but it is worth pausing to consider whether his typological portrayal of the therapist, written approximately simultaneously with the publication of DSM-III, faithfully portrays the culture of the modern DSM and of modern biological psychiatry. Readers will have to judge this for themselves, but there can be little debate that most modern debates within biological psychiatry concern not the appropriate ends of treatment but rather the means most conducive for the attainment of these (mostly assumed) ends; that the clinical psychiatry literature is largely a literature of technical rationality; and that modern psychiatric diagnosis is very much concerned with “facts,” “means,” and “measurable effectiveness.” MacIntyre’s implicit critique,

36 Ibid., 28.
37 Ibid., 25.
38 Ibid., 30.
that therapists themselves are being used as pawns within a much larger bureaucratic
system of containment and control, is one for which modern biological psychiatrists often
have little response beyond incomprehension and indignant (read: “shrill”) protest.39

Emotivism in its various forms is the final consequence, for MacIntyre, of the
failure of the Enlightenment to provide convincing justification for morality.
Kierkegaard’s *Enten-Eller*, with its literary depiction of the radical choice between the
aesthetic and the ethical, both prefigures the rise of emotivism (since radical choice
differs from rational justification for either alternative) and nicely highlights the way in
which neither the reason-centered moral theory of Kant nor the passions-centered moral
theory of Hume can withstand the criticisms of the other. But MacIntyre claims not only
that the enlightenment project of justifying morality has failed – for then we should long
only for a more sophisticated voice to come along – but also that it *had* to fail.

The enlightenment project of justifying morality had to fail, for MacIntyre,
because it had lost the teleological structure on which western moral theory had
previously depended, in both its classical and theistic forms. The classical moral scheme,
articulated most clearly by Aristotle, posited a threefold structure of “man-as-he-happens-
to-be,” “man-as-he-could-be-if-he-realized-his-essential-nature,” and “ethics [as] the
science which is to enable men to understand how they make the transition from the

39 Ironically, for MacIntyre, moral individualism, in which the self understands itself as having no story and
always able to step back from any particularity to cast judgment “from a purely universal and abstract point
of view that is divorced from any particularity” (*After Virtue*, 32), renders the self even more exposed to
manipulation by managerial organizations. “Bureaucracy and individualism are partners as well as
antagonists” (32): when the self is conceived as inexorably set over and above its social surround, rather
than organically and constitutionally embedded within it, it is rendered dangerously vulnerable.
former state to the latter.” In this threefold structure, moral claims are simultaneously factual claims: what one ought to do is, at the same time, what will enable one to realize one’s telos. But the enlightenment eschewal of human reason’s ability to comprehend ends and essences, which MacIntyre blames on Calvinism and Jansenism, declared any teleological conception of human nature epistemologically inaccessible. The enlightenment philosophers were therefore left with a pessimistic construal of human-nature-as-it-is and with injunctions of morality inherited from the prevailing Jewish-Christian-classical culture but without the teleological scheme which imparted these injunctions with their factual content and, therefore, warranted them. The modern Humean fact-value “no-ought-from-is” divide is therefore a predictable historical development, as statements of “ought” appear increasingly ungrounded in what “is.” The fact-value distinction is fallacious as a general logical claim, MacIntyre argues, as is evidenced by the perfectly reasonable conclusion that a farmer with a high crop yield, an effective soil-renewal program, and prize-winning dairy cows is in fact a “good farmer.” This is because “farmer,” like “watch,” is a functional concept, in that both are defined by the functions which each are characteristically expected to serve. “Man” (or, let us say, “humankind”) was, in the classical moral scheme, just such a functional concept, but is so no longer. With the loss of a teleological account of “essential” human nature, moral claims have as a matter of convention lost their factual content. This failure, for MacIntyre, renders strong moral claims helpless against the deconstructive

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40 Ibid., 52.
41 Ibid., 58.
critiques of Nietzsche (and, we might add, for later thinkers such as Foucault) and leads eventually to some variant of emotivism.\textsuperscript{42}

It may seem a stretch to appropriate MacIntyre’s argument about the status of moral claims in modern philosophy in an analysis of the status of psychopathological claims. Surely, one might say, nosological claims are “scientific” or “empirical” in a way that moral claims are not. But I wish to suggest otherwise. “Madness,” as the work of Roy Porter and others (let us here bracket Foucault) has clearly shown, bears a special relationship to Enlightenment rationality.\textsuperscript{43} Though it did not originate with the Enlightenment, the forms in which “madness” was constructed, and particularly in which the treatment of the “mad” was structured, are unintelligible apart from Enlightenment constructions of “reason.” Psychiatry as a profession, historically speaking, is both product and custodian of these constructions. But psychopathological claims have historically borne a different relationship to “reason” than have moral claims. Moral claims have historically functioned for those with the ability to act according to them, to who are sufficiently rational, or ordered, or at least teachable, to respond to them. Psychopathological claims about “madness” or “insanity,” on the other hand, historically functioned to mark the conceptual boundary between those who could appropriate moral

\textsuperscript{42} MacIntyre’s specific examples of “watch” and “farmer” to demonstrate the collapse of the is/ought distinction with respect to functional concepts are, to be fair, not very strong. A non-descriptivist analytic philosopher could presumably retort that “he gets a better yield for this crop per acre than any farmer in the district” entails “he is a good farmer” only because the evaluative language of “better” is already imported into the premise. I believe that MacIntyre’s point can be sustained with more robust counterexamples, but even if not, this does not negate his overall argument. MacIntyre’s basic disagreement is not with those who argue for the is/ought distinction, since such a distinction is understandable enough after the Enlightenment, but with those who see the is/ought distinction as an abiding metaphysical truth rather than as a contingent sociohistorical development. The is/ought distinction, that is, seems valid to many in modernity because, in a particular cultural-philosophical milieu, the “oughtness” of the “is” was rejected.

claims and those who, for whatever reason, could not. This is not to say that psychiatry, or the nineteenth-century asylum, was only about the confinement of those who transgressed Enlightenment standards of reason, but it is to say that “madness” did in fact serve this boundary-marking function. Remembering this historical function of psychopathological language does much to account for why many still assume that the presence of “mental disorder” implies the abrogation of moral responsibility.

The loss of the classical-theistic teleological conception of human nature which MacIntyre describes has a complicated relationship with psychopathological language. One might, for instance, argue that “madness” was enabled by just this loss: as moral claims ceased to be understood in the eighteenth and nineteenth centuries as factual claims and as the justification for morality was therefore understood as increasingly tenuous, new disciplinary regimes such as “madness” needed to arise to enforce the preservation of social norms which could no longer be rationally justified. This is basically the Foucauldian argument, and I do not wish to discount it entirely. But it is not the only potential consequence.

More interesting is the evolution of the function of psychopathological language over the last two centuries. The dominant function of disorder-language in our day is not to enable confinement but, rather, to enable “treatment.” It certainly does not serve as a rigid boundary-marker between those who are rational and those who are not. Freud and the post-Freudians successfully abolished that distinction: after Freud, it is clear that often there is much reason in madness and, conversely, much madness in reason. Correlatively, psychoanalysis successfully applied psychopathological concepts not only
to institutionalized inpatients, as the nineteenth-century asylum psychiatrists had done, but also to more “functional” outpatients. This, however, meant that psychopathological and moral language no longer occupied different conceptual domains; the psychopathological was available to cover territory that had previously been covered by the moral. It would be perfectly plausible, then, if in the face of declining confidence in moral language, the culture began to replace the language of the moral with the newly available language of psychopathology. And that is, for MacIntyre, precisely what the “therapist” has done.  

This move to gradually replace disfavored moral language with psychopathological language would seem even more advantageous if doing so would restore, or at least would seem to restore, the threefold structure of the classical-theistic moral scheme and, therefore, the justification for morality. One might reasonably wonder, therefore, whether “health” and “mental health” have served just this purpose. Most citizens of late-modern culture no longer believe that they believe in a concept of “humans-as-they-would-be-if-they-realized-their-essential-nature,” but most do believe that “mental health” is a state of affairs which is very much to be sought. One can then, without much difficulty, reconstruct the triadic classical moral scheme in modern therapeutic guise: humans-as-they-happen-to-be, humans-as-they-would-be-if-they-were-mentally-healthy, and psychiatry/psychology as the science which is to enable humans to understand how they make the transition from the former state to the latter.

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44 MacIntyre was not the first to advance this general claim; see, for example, Philip Rieff, The Triumph of the Therapeutic: Uses of Faith After Freud (Chicago: Univ. of Chicago Press, 1966; reprint, Chicago: Univ. of Chicago Press, 1987).
The fact that there is no consensus, even among psychiatrists, about exactly what “mental health” is has not so far denied this scheme of its power – but it is certainly possible that history will repeat itself, that the therapeutic disciplines will lose cultural credence just as moral philosophy has, and that psychopathology will degenerate into its own variant of emotivism, where “this is healthy” is understood to mean, roughly, “I prefer this.”

If this analysis, which is admittedly incomplete and schematic, is even plausibly correct, then it should be clear that modern psychopathological language, such as that of the *DSM*, bears the weight of several vestigial histories. There is on one hand the vestigial function of demarcating the outer limit of those who are amenable to the claims of morality, which is why it is often wondered whether “mental disorder” is mutually exclusive of moral responsibility. But there is, on the other hand, the vestigial function of moral language, ceded to psychopathology, which is why proposals to exclude moral responsibility from “mental disorder” categorically seem problematic and unreasonable. And there is, third, the need on the part of some for the weight of the entire moral-therapeutic enterprise to be justified by the pseudoteleological concept of “mental health,” lest psychiatry cease to be a unifying conceptual discourse in a morally fractured society.

It should not be hard to see, if this is true, that weighted with these vestigial and truncated meanings, neither psychiatry nor the culture which enables it will ever be able to make clear conceptual sense of the basic questions “what is mental disorder?” and, more precisely, “how is mental disorder demarcated from other failures of human flourishing?” It cannot make clear conceptual sense of these questions because there is
no clear conceptual account of human flourishing and of “nature” from which to construct intelligible answers. Psychiatry exists, rather, as a practice “in the ruins,” relying for its ongoing integrity on fragments of past conceptual wholes and therefore highly vulnerable to bureaucratic manipulation.

What would be needed, in a MacIntyrean analysis, to reverse this conceptual inadequacy? First, one would need to eschew any hope of achieving consensus based only on a socially disembodied standard of rationality. Second, one would need to begin reconstruct a moral scheme which follows the threefold pattern of the classical/theistic scheme. This requires, at minimum, a teleological conception with which to make moral claims intelligible and a moral conception with which to make psychopathological claims intelligible: even if one rejects the nineteenth-century use of psychopathology as a boundary-marker between those able and those unable to respond to moral claims, one must have a plausible account of ethics if one is to have a plausible account of how psychopathology relates to ethics. In other words, adequate nosology requires an ethics, and ethics requires teleology. And this, MacIntyre firmly argues, can take place only within the “historically extended, socially embodied argument” of a tradition. Psychiatrist diagnosis is, remember, an inescapably political practice.

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46 MacIntyre, *After Virtue*, 222.
4.4 On Moving Forward Without All the Answers

At this point I can anticipate two closely related objections to the arguments developed over the course of this chapter. The first is that if it is true that psychiatry subsists as an incoherent practice due to the absence of sustaining teleological and metaphysical commitments, then the proper response would be to abandon faith in psychiatry and psychiatrists; but because (it might be stated) we need psychiatry and psychiatrists for various practical reasons, this would be too high a price to pay, and so something must be wrong with the analysis. The second is that psychiatry and psychology do not seem incoherent to most practitioners or most patients – in fact, relative to other even more fragmented disciplines such as theology and philosophy, they seem quite conceptually unified and robust – and so something must be wrong with the analysis. For me, the question is an even more existential one. I am a psychiatrist, and not only a psychiatrist, but a psychiatrist who practices currently within an organization (the United States Department of Veterans Affairs) which (rightly, on its grounds) precludes the ordering of psychiatric practice along explicitly teleological (and particularly “religious”) lines. What am I, or we, to do?

The answer I propose will be disappointing and even deflating to apocalyptic MacIntyreans, but it is this: we keep moving forward and celebrate the vestiges of coherence which we possess. The MacIntyrean account of culture does not demand an all-or-none judgment, in which either the culture is robustly unified by enlightenment rationality (which it is not) or fragmented into chaos. It is, rather, an account in which

47 I have no reason to think that MacIntyre himself would disagree with this.
late-modern culture is haunted by the echoes and shadows of partially eclipsed conceptual schemata which are still operative, in unpredictable ways, in the construction of social and political life, and in which “local forms of community” sustain particular practices and therefore particular virtues. Furthermore, no one, or at least almost no one, in late-modern culture is a product of only one “local form of community.” I am (in alphabetical order), among other things, a white male American, a Christian, a faculty member, a father, a husband, a physician, a psychiatrist, a South Carolinian by birth, and a theologian-in-training. Though some of these designations are entailed by others, and though I have very decided commitments about which of these contexts are most important and fundamental, all are essential to (my understanding of) my identity. They each have formed me in particular ways, requiring particular commitments, inducting me into particular communities of speakers, fostering particular virtues, and (absolutely without doubt) leaving me vulnerable to particular vices. The essential MacIntyrean point is not that modern psychiatry shows no internal coherence – on the contrary, MacIntyre endorses medicine as an example of a practice⁴⁸ -- but rather that its coherence is contingent on its self-limitation to the pursuit of internal standards of excellence. But this is not trivial. Relying on my moral formation as a physician and a psychiatrist and pursuing the internal standards of excellence definitive of good practice,⁴⁹ I can engage in

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⁴⁸ Ibid., 194.
⁴⁹ Describing what these “internal goods” are is difficult as, for MacIntyre, internal goods are realized only in the pursuit of a practice and can therefore suitably be appreciated only by those who are engaged in the practice itself. Describing such goods necessarily renders them static and removes them from their immediately practical context. Recognizing them, furthermore, requires something like an aesthetic sensibility; the good psychiatrist is one whose way with patients is beautiful. As a psychiatrist, I know this when I see it in teachers, colleagues, and (sometimes, fleetingly) in myself, and so I believe that these internal goods exist and are worth pursuing. But I do not have confidence that they can alone safeguard
honorable work and participate in the flourishing of others in a way which I
understanding to be commensurable with my formation as Christian. But I should not be
surprised to find that I quickly hit limits, that in some cases the internal goods of
psychiatry are pragmatically insufficient, and that I cannot infallibly distinguish between
the virtuous practice of psychiatry and vicious cooperation with external forces which
seek to use psychiatry (and me) for their own ends. To see that, I must be accountable to
others both within and outside of psychiatry.

In addition, MacIntyreans can rightly celebrate social consensus, when it exists,
so long as that social consensus is commensurable with the virtues of the formative
traditions of which one is a part. A psychiatrist of nearly any traditional formation can
diagnose acute mania as pathological and initiate technological treatment because our
pluralistic culture, profoundly riven with disagreement about so many issues, can still
agree that acute mania is inconsistent with human flourishing and is appropriately
demarcated as psychopathology. In a similar way, I confess that I do not fully understand
why our political and legal systems, in the face of libertarian protest, continue to structure
involuntary commitment laws in such a way that allow psychiatrists to invoke the police
powers of the state in an effort to keep a person from completing suicide – but I am glad
that they do, and can celebrate the ability to continue to practice psychiatry in a context
which, for vestigial moral reasons, prizes the preservation of life.

psychiatric practice against the powerful external forces (particularly economic forces) which threaten to
industrialize psychiatry and, like MacIntyre’s bureaucracy, efface both the cultivation and the celebration
of these goods.

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MacIntyreans who are fond of psychiatry and psychology, therefore, need not despair; there is enough internal coherence in these practices, and enough vestigial social consensus on key moral and clinical categories, for them to go on. But Christians seeking to engage psychology and psychiatry should not settle for this. This is not only because a “theology of mental illness” built on the foundations of a conceptually impoverished psychiatry will end up even more conceptually impoverished – though this is no doubt true. It is rather that clinical psychiatry and psychology, for reasons I have attempted to show in this chapter, need the conceptual and practical “something more” that theology can provide. This is as far as we can go with a “bottom-up” analysis of why psychiatry needs something like theology, and something like a church. But it is the imaginative privilege of Christians, working within a particular cultural-linguistic context, to propose not just constructive answers, but ones which are beautiful.
5 The Moral Work of Psychiatric Diagnosis

In the three preceding chapters, I have argued both from the psychiatric clinical literature and from contemporary (non-theological) work in the philosophy of psychiatry that “biological psychiatry” as a clinical discipline is practically informed and guided not by neurobiology alone but also (and primarily) by traditions of contemporary psychiatric nosology which are informed by but by no means emergent from neurobiological research. I have argued that denoting what counts as “mental disorder” or “mental illness” is by no means a straightforward empirical question but is, rather, one which is inseparable from the historical/clinical development of modern nosology and, furthermore, continues to be heavily debated in the clinical and philosophical literature. Applying Alasdair MacIntyre’s work in moral theory to the contemporary DSM, I have argued that psychiatric diagnosis should properly be understood, and acknowledged as, tradition-constituted discourse, and that this should in turn lead to transparent self-examination of the moral strengths and moral vulnerabilities of the DSM’s formative and sustaining communities. Furthermore, I have argued that psychiatric diagnosis which is capable of withstanding genealogical critique must be able to provide some account of how teleological judgments of contextual “fittingness” are rendered and also must provide some way to demarcate medical failures of flourishing from failures of flourishing that are better described within non-medical forms of language.

At this point we could reasonably conclude Part One of this work and move straightaway to the constructive Thomistic engagement of Part Two. Such a move,
however, would be premature, since there is an important potential objection which the
previous chapters have not fully addressed. A thoughtful critic – a theoretically grounded
clinical psychologist, for example – might agree with the overall argument of this work
and yet wonder why such a detailed analysis is necessary to critique the widespread use
of psychiatric medication and other somatic technologies within contemporary mental
health practice. “Why, yes,” such a critic might say, “neurobiology, as psychologists
have always known, cannot ground the practice of psychiatry, and psychiatric diagnosis
is a historically contingent, tradition-bound project. But the fact that diagnosis is
considered necessary to legitimize the use of somatic technologies in no way entails that
diagnostic judgments require the use of these technologies. There are, after all, effective
psychotherapies for many major mental disorders. The problem is not with clinical
diagnosis per se, but rather with the way that psychiatrists and other prescribing
clinicians leap from the presence of a diagnosis to the use of medication without
employing appropriate psychotherapies first. Rather than revisiting the diagnostic
tradition as a whole, why not just focus less on somatic technologies and more on the
person-centered work of psychotherapy? Wouldn’t more reliance on psychotherapy, and
less on medication, solve the problem of the technicization of psychiatry without
requiring a revisitation of the diagnostic project as a whole?”

If the power of psychiatric diagnosis resided only in its provision of theoretical
legitimacy to the use of somatic technology, such a critique would be persuasive. But my
project in this chapter is to argue that the power of psychiatric diagnosis is much broader
and deeper, setting the linguistic context not only for the choice of one treatment over
another but, rather, for the intelligibility of “treatment” as an appropriate situational response. The technologizing of mental health would not be stopped by preferential choice of psychotherapy over medication and other somatic intervention, because the psychotherapies themselves are increasingly understood, in contemporary psychology and psychiatry, as *technai* in their own right, means to be employed for the achievement of particular pre-specified ends.¹ Psychiatric diagnostic language not only confers legitimacy on the use of particular technologies in particular situations but also initiates the affected individual into a particular interpretive context and, in so doing, forms a self which is capable of submitting to technological intervention. It is this constructive role of diagnosis which is the focus of this chapter. Put more bluntly, once one reaches the point of selecting psychotherapy or medication as the “treatment” for a particular presentation of “mental disorder,” one is already deeply implicated in the technical project of modern medicine and one’s conceptual horizon is, for the most part, restricted to the medical.

A comprehensive review of literature arguing for the interpretive function of psychiatric language would be an immense undertaking which is beyond the limited scope of this chapter. The psychoanalytic tradition, in particular, features a number of thoughtful analyses both by clinicians² and non-clinicians³ of the hermeneutic character of psychoanalytic interpretation. It is notable, however, how little influence this

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¹ This is the essential logic, as described in detail later, behind the “evidence-based psychotherapies,” so called because they are amenable to investigation within the context of a clinical trial. For a contemporary description of techne, see Joseph Dunne, *Back to the Rough Ground: Practical Judgment and the Lure of Technique* (Notre Dame, Ind.: Univ. of Notre Dame Press, 1992).
hermeneutic literature commands within the scholarship of biological psychiatry and clinical psychiatry as a whole. My argument in this chapter will therefore take a different form; rather than recounting previous arguments about psychiatric interpretation, I will narrate how one contemporary DSM diagnostic category, post-traumatic stress disorder (PTSD), functions recursively to construct the experience of those so diagnosed. PTSD, I will argue, places patients in an ambiguous relationship to the moral context of their experience. Initially proposed as a contextual diagnosis which focused attention on the person’s toxic environment rather than on the person’s internal psychological or biological structure, it has in the course of its three-decade history been progressively medicalized and technicized so as, now, to obscure in part precisely the moral context of trauma that it was intended, initially, to highlight.

Some may object that my decision to frame the argument in this way – focusing on the social history and linguistic function of one disorder-category rather than “mental disorder” as a whole – compromises the generalizability of my argument, for the simple reason that what applies to PTSD may not apply to other mental disorders. This is certainly true – but its truth confirms, rather than negates, the necessity of a particular rather than general approach to “mental disorder.” PTSD, bipolar disorder, schizophrenia, major depressive disorder, borderline personality disorder, and other generally accepted DSM-ratified “mental disorders” all have particular and very different histories, uses, and social connotations, linked to each other more by family resemblance (at best) than by any common essence. As such, they require independent narration.

Precluded by time and space from a more comprehensive survey and mindful of
important historiographic work done on other diagnostic categories, this account centers on PTSD for several reasons. First, despite its relatively recent introduction into the DSM nomenclature (1980), it has entered the common language of the culture, is central to contemporary sociopolitical discussions relative to the recent American war efforts in Iraq and Afghanistan, and is widely spoken of in realist and essentialist terms. Second, it is the focus of several well-reasoned historical and anthropological investigations, particularly Allan Young’s *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*, from which this chapter draws heavily. Third, it provides a fascinating case study, as I will argue below, of the transformation of frankly moral into clinical language. Fourth, it is central to my own work as a clinician within the Department of Veterans Affairs healthcare system. Because of this, and because the history of combat-related PTSD differs somewhat from the history of PTSD related to other forms of trauma (e.g., rape and sexual trauma), I will focus my analysis on combat-related PTSD as experienced by soldiers during and after combat deployment. I have no reason to think, however, that the broad outlines of the argument I make here could not be easily modified to these other equally important manifestations of PTSD.

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5.1 Two Brief Histories of PTSD

The history of post-traumatic stress syndromes is often narrated in psychiatric and other clinical literature as a movement of progressive, if somewhat erratic, discovery. Trauma, in this standard account, is an essential part of human history, and the human response to trauma which is now commonly recognized as PTSD is traceable, albeit in fragmentary form, in the earliest works of literature, including the Epic of Gilgamesh, the Iliad, and even the Bible. Despite this fragmentary appreciation throughout documented history, however, posttraumatic stress as a clinical syndrome awaited the emergence of modern medicine and psychiatry in the mid-19th century, when medical observation of the sequelae of industrial and railway accidents (e.g., “railway spine”) and then of combat trauma gave rise to undisciplined but formative nosological speculation. The astonishing rates of psychological suffering among soldiers and veterans of the First World War, in particular, attracted the attention of British and continental military psychiatrists who produced several diagnoses (particularly “shell shock”) which are now recognized as important but incomplete diagnostic forerunners of PTSD. Freud’s reflections on war veterans in Beyond the Pleasure Principle (1922), in which he advanced the theory of the death instinct and of traumatic “repetition compulsion,” also

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7 See, for example, Aiton Birnbaum, “A Biblical Case Study of Posttraumatic Stress Disorder,” Journal of Aggression, Maltreatment, and Trauma 14 (2007): 75-86, which narrates the recurrently traumatized Jacob as a PTSD sufferer.
8 Young, The Harmony of Illusions, chapters 1-2.
9 Ibid., 52-53.
contributed to the culture’s understanding of the effects of trauma.\textsuperscript{10} \textit{DSM-I}, published in the years immediately following the Second World War, included a general but rather nonspecific category, “gross stress reaction,” which acknowledged the symptoms currently recognized as PTSD but was too nonspecifically defined to be of much clinical or research use. \textit{DSM-II}, edited in the 1960s before Vietnam-related trauma was properly recognized, inexplicably dropped this category and therefore contained no specific post-traumatic stress category. This was finally, albeit painfully, rectified in the 1970s, when advocacy by psychiatrists and veterans groups attuned to the experience of returning Vietnam combat veterans persuaded the American Psychiatric Association (over the objections of the Veterans Administration) to create a new category for \textit{DSM-III}, “Post-traumatic stress disorder,” which accurately named the clinical symptoms of these veterans. PTSD and trauma, however, exist not only among combat veterans; the diagnosis of PTSD has been found to apply as well to victims of human-caused disasters such as Hiroshima,\textsuperscript{11} to victims of sexual assault and violence,\textsuperscript{12} to the victims of natural disasters,\textsuperscript{13} and even to witnesses of salient cultural traumatic events such as the events of

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September 11, 2001. Once virtually ignored within psychiatry, it is now recognized as a major domestic and international public health concern.

This has become in many ways the received account of PTSD in contemporary American culture. But there is another way of construing “trauma” and “PTSD” which, while fully acknowledging the human suffering which “trauma” names, does not see either “trauma” or “post-traumatic stress disorder” in essentialist terms. According to this historical/anthropological account, “trauma” names a conceptual framework by which modern medicine and psychiatry narrated, classified, and treated the particular forms of human suffering which corresponded to extraordinary pathos-generating life events. The emergence of trauma syndromes within psychiatric diagnosis culminating with the modern construct of PTSD is in this account less a narrative of progressive discovery and refinement than a product of historical and political contingency; the way that a culture narrates “trauma” both reflects and shapes that culture’s ongoing self-understanding. Allan Young is perhaps the most prominent proponent of this view, joined by a diverse group of others such as Patrick Bracken, Derek Summerfield.

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Mark Micale, and Didier Fassin and Richard Rechtman. In a programmatic paragraph, Young argues that the essentialist, ahistorical narration of PTSD is “mistaken.”

The disorder is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources. If, as I am claiming, PTSD is a historical product, does this mean that it is not real? . . On the contrary, the reality of PTSD is confirmed empirically by its place in people’s lives, by their experiences and convictions, and by the personal and collective investments that have been made in it. My job as an ethnographer of PTSD is not to deny its reality but to explain how it and its traumatic memory have been made real, to describe the mechanisms through which these phenomena penetrate people’s life worlds, acquire facticity, and shape the self-knowledge of patients, clinicians, and researchers.

Young’s work combines history, theory, and ethnography to argue that although suffering in the context of painful remembering is likely ubiquitous in human history, the “traumatic memory” – a memory linked to a discrete “trauma” and then forgotten through such mechanisms as repression and dissociation – was the invention of 19th-century European culture, which thereby revised the Western concepts of free will and self-knowledge and “justified the emergence of a new class of authorities, the medical experts who would now claim access to memory contents that owners (patients) were hiding from themselves.” Mid-nineteenth-century physicians such as Herbert Page (1883), Jon Furneaux Jordan (1880), Jean-Martin Charcot (1889), George W. Crile and Walter B.  

20 Young, The Harmony of Illusions, 5-6.  
21 Ibid, 4-5.
Cannon (1899) posited an association between fear and physiologic dysfunction and dysregulation, but Young argues that the concept of traumatic memory as the encoding of an event emerged from Theodule Ribot’s description of “periodic amnesia,” Pierre Janet’s work on hypnosis, and particularly Freud’s description and subsequent rejection of the seduction theory of neurosis. The traumatic memory, for these thinkers, described an event (or, for Freud, a wished-for event) and could, when repressed, exert pathological influence; this depends, for Young, on the “medicalization of the past” and the “normalization of pathology.” This focus on discrete memory affected certain psychiatrists such as W.H.R. Rivers who cared for patients in the First World War, who in turn influenced mid-20th-century psychoanalytic theorists of war neurosis such as Abram Kardiner. Young argues that DSM-III, despite its general disavowal of the term “neurosis” and its general coolness to psychoanalysis, in fact inscribed Freud’s conception of the traumatic memory into the construct of PTSD by emphasizing the linear relationship between a memory of a particular event (or set of events) and psychiatric suffering and disability in the present.

5.2 Vietnam and the Origins of “PTSD”

PTSD as a diagnosis (hereafter referred to as “PTSD”) would not have appeared in DSM-III at all, however, were it not for the determined efforts of a small group of psychiatrists and advocates to highlight the particular suffering of American Vietnam

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22 Ibid., 26-38.
23 Ibid., 39.
24 Young, “When Traumatic Memory Was a Problem.”
combat veterans during the Vietnam War era. “PTSD” arose, that is, in a very particular cultural/political milieu. Although the Second World War had alerted the American military and (to a much lesser extent) the American population to the widespread risk of psychiatric dysfunction among returning combat veterans, initial estimates of psychiatric casualty (removal from front-line combat for psychiatric reasons) were quite low in the first years of the Vietnam conflict. This early estimate of low prevalence of psychiatric casualty may have been influential in the elimination of the DSM-I diagnosis of “gross stress reaction” in DSM-II, which was published in 1968. Furthermore, returning Vietnam veterans who presented with anxiety-related symptoms (for instance, within the Veterans Administration) frequently met with psychoanalytically-oriented clinicians who largely ignored their combat experience while searching for the causes of neurotic anxiety in the patient’s early psychosexual development.

This particular combination of psychiatric neglect of war experience with the increased frequency, in the late 1960s, of Americans returning from Vietnam with deep psychological turmoil, provided fertile ground for the activism of several protest-minded clinicians. American psychiatry in the 1960’s, largely unlike contemporary American psychiatry, included a movement often referred to as “social psychiatry,” which attempted to situate mental illness not (only) in the biological disposition of the patient but (often, and sometimes primarily) in the patient’s social environment.25 Robert Jay Lifton of Yale served as a prominent voice in this movement, and Lifton, psychiatrist Chaim Shatan, and social worker Sarah Haley, along with several others, are widely

credited with leading the movement which resulted in the institution of PTSD in the
DSM-III nomenclature. Lifton, who is the only one of the three still alive in 2011, was a
psychoanalytically trained psychiatrist whose most recent scholarly study prior to his
engagement with Vietnam veterans was of the civilian survivors of the Hiroshima
bombing. In the prologue to his study of Vietnam veterans, he states that he had been
interested in Vietnam at least since a visit to Indochina in 1954 with his journalist-wife
and that in the years during which the war unfolded,

I developed two strong commitments. One was to psychohistorical investigation,
to developing new theory and method for applying psychological principles to
historical events. The other was to opposition to nuclear weapons and to the war
system in general, and through a deepening involvement in peace-movement
activities, to the war in Vietnam in particular. I struggled to find ways to bring
together the two commitments, to bring passion to investigation, and scholarship
to political and ethical stands.

Lifton writes that reading about the My Lai atrocity in the New York Times in November
1969 brought “an abrupt change” in his relationship to the war. Drawing on his
experience as an Air Force psychiatrist in Korea in the 1950s, and seeking to engage in
“advocacy research,” in which intellectually rigorous investigation is combined with
commitment to broader social principles, causes or groups, Lifton began to interview
Vietnam veterans and soon helped to initiate a two-year series of weekly “rap groups” at
the New York office of Vietnam Veterans Against the War (VVAW). Lifton’s contact
with antiwar veterans led eventually to his 1974 monograph Home from the War:

Vietnam Veterans: Neither Victims Nor Executioners, which he makes clear is neither

26 Lifton, Death in Life
27 Lifton, Home From the War: Vietnam Veterans: Neither Victims Nor Executioners (New York: Simon
28 Ibid., 17.
simply a report on the rap groups nor a representative study of American Vietnam veterans (since most Vietnam veterans of the time either supported the war or, more frequently, were ambivalent and/or overtly apolitical). Rather, Lifton writes,

[this book] explores certain remarkable feelings and images brought back from the Vietnam War, and their bearing on both the nature of the American involvement in that war and of war in general. Above all it depicts a process of individual and collective transformation from war to peace, and of radical subversion of the warrior myth. The book also examines new kinds of group and individual relationships on behalf of shared social and therapeutic goals, which, in turn, connect with struggles throughout the society to create new institutions or to restructure old ones. Finally, it is about psychiatry (and by extension, other healing professions, psychological and theological), its corruptions as revealed in the Vietnam War, and its possibilities for a transformation of its own. In short, the book deals with what is probably man’s oldest and fundamental theme, that of death and rebirth, suffering and realization.29

In this mode, Lifton begins his work with an engagement of My Lai, narrating the combat milieu of the infamous Charlie Company (who killed approximately 350-500 unarmed Vietnamese civilians, including many women, children, and elders, in the Vietnamese village of My Lai on March 16, 1968) as an “atrocity-producing situation,” created by a special combination of elements described by Sartre as “inevitably genocidal:” a counterinsurgency war undertaken by an advanced industrial power against a relatively underdeveloped revolutionary movement in which the guerillas are thought to be inseparable from the rest of the population.30 Lifton’s point here was not to exculpate the American perpetrators but rather to show that “given the prevailing external conditions,

29 Ibid., 19-20.
30 Ibid., 41.
men of very divergent backgrounds – indeed just about anyone – can enter into the ‘psychology of slaughter.’”

Lifton’s subsequent monograph starts with a description of the guilt, anger, and existential questioning of returned (anti-war) Vietnam veterans and progresses into a sharp critique of American involvement in Vietnam. Healing for the Vietnam veteran, Lifton proposes, must take the form of “continuous psychic re-creation” brought about by confrontation with death and with death anxiety, reordering the self so as to move from “static” to “animating” (e.g., motivating) guilt, and finally renewal of the self through a recovery of play. But after offering these broad therapeutic suggestions, Lifton worries that the specifically moral aspects of post-combat remembering will be obscured or effaced by the involvement of psychiatrists. He sharply critiques the role of military psychiatrists in Vietnam:

Consider once more the case of psychiatry and the military. We have observed the part played, even if inadvertently, by the military psychiatrist in Vietnam who helps men adjust to their own atrocities. Whatever his intentions, he is in collusion with the military in conveying to individual GIs an overall organization message: ‘Do your indiscriminate killing with confidence that you will receive expert medical-psychological help if needed.’ Truly this is the psychiatry of the executioner. The psychiatrist is brought to this point by the combination of a particularly evil and counterfeit war with the advanced technicism of his own profession – the unexpressed assumption that his knowledge and skill are useful and good, no matter where applied.

Similarly, Lifton worries that describing the suffering of returned veterans in clinical language will efface the way that the veterans’ experience witnesses to moral truth.

\[31\] Ibid., 42.
\[32\] Ibid., 386.
\[33\] Ibid., 388–408.
\[34\] Ibid., 414.
There are indeed distinctive psychological patterns among returned Vietnam veterans, he writes, but “post-Vietnam syndrome,” the often-used but unofficial term for describing these patterns,

is a dubious, easily-abused category, especially in its ready equation of effects of the war with a clinical condition (a ‘syndrome’). That has been done, for instance, in relationship to various forms of rage, guilt, and protest which, as I have suggested, are actually appropriate to the experience and can be expressed in constructive, ‘healthy’ ways. The implication that can often accompany the use of the term is that normal or desirable behavior . . . would be to adapt quietly to existing American social and war-making arrangements.”

“We still have a very great deal to learn about the psychological casualties of Vietnam,” Lifton writes,

but we can say now that the evidence strongly suggests that even the relatively narrow sphere of ‘effectiveness’ of treatment and ‘prevention’ is inextricably bound up with ethical issues. Psychiatric technicism, in denying that link, falsifies the effects of the war and further corrupts the profession.

Lifton found common cause with two other clinicians: Sarah Haley, a VA social worker in Boston who began speaking out about the moral experience of combat veterans when one of her first patients (later interviewed by Lifton) described tormenting recollections of the My Lai atrocity and who published an influential paper, allegedly censored for a time by the VA, in which she urges clinicians to take seriously veterans’ reports of participation in atrocities and not to dismiss them as neurotic; and Chaim Shatan, a psychoanalyst and fellow anti-war psychiatrist who freely employed the term “post-Vietnam syndrome” as a way to arouse public sentiment against the Vietnam war

35 Ibid., 420ff.
36 Ibid., 421.
and public empathy with the experience of veterans.\textsuperscript{39} Galvanized by their experience with Vietnam veterans and (at least for Lifton and Shatan) by their anti-war political convictions, these three clinicians joined with veterans advocacy groups to push, notwithstanding Lifton’s caution in \textit{Home From the War}, for the inclusion of a post-combat diagnostic category in \textit{DSM-III}, which was entering the early planning phase. Scott (1990), in an article which included personal interviews with many of the key players and which has become the standard history of the inclusion of PTSD in \textit{DSM-III}, reports that Shatan, upon hearing that Robert Spitzer (the newly appointed \textit{DSM-III} Task Force chair) did not foresee the inclusion of a post-traumatic neurosis category in \textit{DSM-III}, quickly mobilized the support of Lifton to lobby for a new category. They met resistance from Eli Robins and colleagues from Washington University (see Chapter 2) who opposed the proliferation of diagnoses within \textit{DSM-III} and who argued that the problems of Vietnam veterans could be accounted for by other diagnostic categories (e.g., panic disorder, alcohol dependence, and so on) and that therefore no new category was needed. To counter this opposition, Shatan, Lifton, Haley and several others formed a Vietnam Veterans Working Group to plan a strategy for convincing the \textit{DSM-III} Task Force to include a post-combat category. When in the context of engaging contemporary research, the group noted similarities in the experience of combat veterans and of survivors of other highly adverse situations (e.g., Nazi concentration camp survivors), the group expanded its membership to include clinicians and researchers interested in areas

other than combat stress. After a series of behind-the-scenes efforts to enlist the support of key members of the DSM-III Task Force, the committee recommended a \textit{DSM-III} category of “catastrophic stress disorder,” further categorized into acute, chronic, and delayed subtypes. The \textit{ad hoc} DSM-III Committee on Reactive Disorders, and then the Task Force, eventually accepted the proposal, renaming it “post-traumatic stress disorder (PTSD)” and playing down the distinction between natural disasters and human-generated disasters.\footnote{Wilbur J. Scott, “PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease,” \textit{Social Problems} 37 (1990): 294-310.} The final text version of the PTSD criteria was drafted by Nancy Andreasen, the Donne scholar-turned-biological-psychiatrist, later the editor-in-chief of the \textit{American Journal of Psychiatry}, who became convinced that the Vietnam advocates were describing a characteristic human response to trauma which she had also observed in her work with severely burned patients.\footnote{Nancy C. Andreasen, “Acute and Chronic Posttraumatic Stress Disorders: A History and Some Issues,” \textit{American Journal of Psychiatry} 2004 (161): 1321-1323.}

\section*{5.3 The Moral Work of PTSD}

Once ratified in \textit{DSM-III}, PTSD, like any diagnostic construct, escaped the control of its authors and became a resource by which clinicians and patients, if they so desired, could reshape clinical care. As it turns out, clinicians and patients did find the construct useful and PTSD has since become an enormously influential conceptual anchor in mental health treatment both in the United States, where the construct originated, and in other regions of the world. It has continued to exert enormous influence in structuring the psychiatric care of combat veterans, in part due to large
expenditures by the U.S. government to fund research and clinical programs in the VA system, but has also proved enormously influential in the clinical literature regarding rape and sexual violence, in recovery from non-combat injuries, and in narrating the experience of traumatized populations (including, controversially, the U.S. population after September 11, 2001). A professional organization devoted to facilitating trauma studies, now called the International Society for Traumatic Stress Studies (ISTSS), was founded in 1985, and its flagship journal, the *Journal of Traumatic Stress*, was founded in 1986.\(^{42}\)

Although the construct of PTSD has never been unanimously accepted within psychiatry and a series of important recent articles have questioned various aspects of its validity,\(^ {43}\) it is not my purpose in this chapter to argue for or against the clinical value of the PTSD diagnostic construct.\(^ {44}\) As a VA clinician, I see many patients whose

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42 For a celebratory history of the ISTSS which nicely displays what I refer to as the standard account of PTSD, see Sandra L. Bloom, “Our Hearts and Our Hopes are Turned to Peace: Origins of the International Society for Traumatic Stress Studies,” in *International Handbook of Human Response to Trauma*, ed. Arieh Y. Shalev, Rachel Yehuda, and Alexander C. MacFarlane (New York: Kluwer Academic/Plenum, 2000), 27-50. As a matter of historical interest, Bloom helpfully highlights the important organizational role that the National Council of Churches and several protestant bodies, including the Lutheran Church (Missouri Synod) and the United Presbyterian Church, played in the early protest movement related to “post-Vietnam syndrome” and in the early years of the ISTSS.


44 In the argument that follows I will refrain from using the term “validity,” lest an already long discussion become unnecessarily complicated. There are many forms of “validity” in statistical research, but the validity of a diagnostic construct is most often a question of construct validity, i.e. whether a certain diagnostic construct reflects natural patterns of psychopathology. The Robins and Guze (1970) validity criteria, for which modifications have been proposed over the years, propose one model for measuring the validity of psychiatric diagnoses (as discussed in Chapter 2). But if, as I argue here, describing a “mental disorder” in a certain way recursively affects the way that human experience is named and organized, then language about the validity of any diagnosis is potentially misleading. I will therefore avoid it here. See Eli Robins and Samuel B. Guze, “Establishment of Diagnostic Validity in Psychiatric Illness: Its Application to Schizophrenia,” *American Journal of Psychiatry* 126 (1970): 983-987.
experience and behavior quite clearly aligns with the prototypical description of PTSD; “PTSD” names their experience in a way that no other DSM-IV construct does. Although I am mindful of the recent criticisms, therefore, it is difficult for me not to see PTSD as a useful and valuable construct. I am aware, however, that it is highly plausible that I consider “PTSD” useful in part because I am a psychiatrist trained in a medical culture in which both clinicians and patients have been habituated over the past three decades to interpret human reaction to extreme adversity through the lens of “PTSD.” If, that is, “PTSD” provides a useful and helpful way for suffering people to narrate their experience, specifically by orienting it to a precipitating “traumatic event,” then PTSD need not exist “out there” to possess very strong “face validity.”

Take, for example, a fictional but plausible case of an Iraq veteran who receives a diagnosis of PTSD. Joseph Cox, we might call him, is a 23-year-old infantryman recently discharged from the Army after two 15-month deployments to Iraq, during which he witnessed and participated in the urban warfare which is by now a well-documented feature of that war. In the service, he performed his work satisfactorily and found the straightforward command structure of the military somewhat reassuring, giving him a very concrete structure with which to distract himself from increasingly desperate guilt and anxiety. Once home with his wife and infant son, however, things seem to fall apart. He begins drinking large quantities of alcohol which had not been available to him in Iraq. He attempts to find work but is able to secure only a part-time job as a grocery bagger, a job which he finds demeaning and boring and from which he is fired after a heated argument with a customer. His marriage soon begins to unravel as heated
arguments with his wife over seemingly small issues turn, on several occasions, into threats of violence. He finds himself thinking nearly all the time about Iraq, tormented by visions and nightmares of dead comrades, dead Iraqis, dead children, and at the same time remembers the “limit experiences” of war with a certain wistfulness; he feels that he would be better off there again than continuing his self-destructive and hopeless life in the United States. He seriously contemplates suicide.

Receiving and internalizing a diagnosis of PTSD has, for Joseph Cox, linguistic and symbolic consequences of which he might be only dimly aware and about which he might be in many ways ambivalent. First “PTSD” might offer him a contextualizing narrative for his present dysfunction which serves both to ameliorate his shame and to induct him into a new community of common language-speakers. The implicit message from a clinician might be summarized as follows: “You may think that you are a screw-up and that your life is destined for failure – but you are not. You have post-traumatic stress disorder, a combat injury just like any other more physical injury, and as such you are a wounded warrior. Furthermore, you are not alone, as up to 30% of returning Iraq veterans will develop some degree of PTSD as well. So let me introduce you to other veterans with PTSD, to this patient-information literature, and above all to this array of evidence-based treatments, including talk therapies and medications, which are proven to effectively treat or even to cure PTSD.” Second and more radically, however, “PTSD” offers him a way to reframe his understanding of the relationship between his experience and himself as the agent of his experience. The frustration, fear, thrill-seeking, and rage which Mr. Cox had heretofore apprehended (inchoately, perhaps) as his experience
suddenly becomes something very different. They are no longer straightforwardly intrinsic to “him;” rather, he is informed that they are “symptoms” of a “disorder” which he “has.” He is still, of course, the subject of his experience but is no longer the sole author of it. There is something inside and yet extrinsic to him, “PTSD,” which needs to be “treated” in order for him to regain mastery in his life. When he visits his biologically-oriented VA psychiatrist, he is asked questions about these “symptoms:”

*How frequent are your nightmares? How much are you sleeping? How often do you have intrusive thoughts about Iraq? Are you still unable to be in crowded places?*

Above all, he is taught that his “symptoms” are linked (causally, no one quite says, but he reasonably assumes) to a set of “traumatic events” which justify his PTSD diagnosis. The freedom afforded him by “PTSD” turns out to be the freedom to embrace a medical/psychological model of his experience and to embrace the treatments made possible within the conceptual horizon of the medical.

This medicalization of combat and post-combat experience, however, demands moral analysis. This is the case, first, because “PTSD” often cannot stand on its own as a conceptual/linguistic system without moral explication, for the simple reason that the “traumatic event” is understood as a subjective, and therefore an interpretive, phenomenon. The diagnostic construct of PTSD depends on the specification of a traumatic event, but gives no guidance (particularly in its *DSM-IV-TR* form) as to how or why the traumatic event is interpreted as traumatic. Why, one must always ask, is the “traumatic event” interpreted as “traumatic” in the first place? The answer here cannot always be reductively physiological (e.g., “sympathetic discharge” or “stress-hormone
release”) or reductively behaviorist (invoking, for example, S-R learning theory) because neither of these reductions can, in a satisfactory way, account for why particular experiences (e.g., killing an unarmed child while on a patrol) are interpreted as “traumatic.” Understanding why many “traumatic events” are interpreted as such requires higher-level moral analysis; without openness to moral consideration, PTSD as a diagnostic construct is rendered incomplete and, in some cases, incoherent.

The fact that the medical/psychiatric explanatory scheme is unable fully to substitute for the moral, however, does not mean that the medical/psychiatric (in this case, “PTSD”) cannot do a significant amount of moral work without naming its specific moral sources – and this where contemporary political discourse about combat-related PTSD is quite revealing. Take, for example, the following three documents, chosen not because they reflect all contemporary views regarding combat-related PTSD but because, in my view, they accurately reflect the way that combat-related PTSD is spoken of by contemporary leaders of medicine and government.

First, we might examine a widely-cited study conducted by the RAND Corporation and funded by the California Community Foundation regarding the mental health sequelae of military deployment in Iraq and Afghanistan. The document combines literature review with a survey of over 1900 recently returned military veterans and calls for increased availability of mental health treatment resources, particularly “evidence-based” treatment methods, among returned veterans. The conceptual framework for the document is clearly disclosed in its title, Invisible Wounds of War. In

the summary which opens the work, the authors explain that though modern medical
technology has helped to avoid higher physical casualty rates associated with military
service, “casualties of a different kind are beginning to emerge – invisible wounds, such
as mental health conditions and cognitive impairments resulting from deployment
experiences.”46 Explaining the limitation of the scope of the study’s analysis to PTSD,
major depressive disorder, and traumatic brain injury (TBI) among returned troops, the
authors explain that

these are the conditions being assessed most extensively in servicemembers
returning from combat. In addition, there are obvious mechanisms that might link
each of these conditions to specific experiences in war – i.e., depression can be a
reaction to loss; PTSD, a reaction to trauma; and TBI, a consequence of blast
exposure or other head injury. Unfortunately, these conditions are often invisible
to the eye. Unlike the physical wounds of war that maim or disfigure, these
conditions remain invisible to other servicemembers, to family members, and to
society in general.47

The RAND study presents an excellent overview of data regarding PTSD, major
depression, and traumatic brain injury in Iraq and Afghanistan veterans and makes
careful recommendations based on these data, but it is important to notice the way that a
priori linguistic commitments like “mental health conditions” and, particularly, “wound”
in relation to the set of behavior and experience known as PTSD serves to legitimate the
logic of the report: just as the military, the VA, and the nation as a whole bear
responsibility for caring for those with physical wounds, so also the military, the VA, and
the nation as a whole bears responsibility for caring for those with “invisible”
psychological wounds. Although I am sympathetic to this broader point, it is nonetheless

46 Ibid., xix.
47 Ibid., xx.
important to recognize that the use of the term “wound” to describe PTSD and major depression is a rhetorical claim. “Wound” finds its primary use within the practices of surgery and internal medicine; to speak of a psychological reaction to loss or extreme stress as a “wound” is to invoke metaphor. But this assertion that PTSD and major depression are wounds enables the study authors to recommend uniform and widely available access to “evidence-based treatments” for these wounds. Indeed,

delivery of evidence-based care to all veterans with PTSD or major depression would pay for itself, or even save money, by improving productivity and reducing medical and mortality costs within only two years. Providing evidence-based care is not only the humane course of action but also a cost-effective way to retain a ready and healthy military force for the future.”

Second, we may consider a document written for patients and families by the National Center for PTSD of the Department of Veterans Affairs. The document, titled “What is PTSD?,” describes in relatively jargon-free language the symptoms, prognosis, and preferred treatments for PTSD deemed appropriate for general consumption by the VA. PTSD is “an anxiety disorder that can occur following the experience or witnessing of a traumatic event.” After briefly listing the characteristic DSM-IV symptoms of PTSD, the document states that in addition

we now know that there are clear biological changes that are associated with PTSD. PTSD is complicated by the fact that people with PTSD often may develop additional disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health. These problems may lead to impairment of the person’s ability to function in social or family life, including occupational instability, marital problems and family problems.

48 Ibid., 449.
Fortunately, PTSD “can be treated with psychotherapy (‘talk’ therapy) and medicines such as antidepressants;” but “unfortunately, many people do not know that they have PTSD or do not seek treatment.”

The intention of this document is admirable and it is indeed accessible and clearly written, but its rhetorical organization should be clear. PTSD is defined *a priori* as an “anxiety disorder” with particular “symptoms” resulting from exposure to a “traumatic event.” It is “associated” with biological changes and, in conjunction with “additional disorders” which often co-occur with PTSD, it “[leads] to” social, occupational, and marital dysfunction. The way to prevent this dysfunction from occurring is to engage in appropriate forms of “treatment.”

Most interesting, however, is the document’s assertion that “many people do not know that they have PTSD.” It is common enough, in medicine, for individuals not to be aware of a festering or emerging disease process which becomes clear after an appropriate diagnostic workup: one can easily think of undetected cancers, atherosclerotic disease, autoimmune diseases, and so on. But in most cases, this is because the diagnostician determines a cause for particular symptoms which were not evident from the symptoms alone (or, in the case of a screening examination, which had not yet manifest any symptoms). But this is not how most mental disorders in the *DSM* tradition, including PTSD, work. PTSD is not the cause of its symptoms; PTSD *is* its symptoms. To state, then, that someone can “have” PTSD but not “know” that he or she “has” PTSD is to show that “PTSD” names more a *reorganization* and *re-narration* of
experience than a cause of experience. To see oneself as suffering from “PTSD” is, in other words, to undergo a kind of conversion.  

Third and finally, we might examine U. S. President Barack Obama’s description of PTSD in his radio address to the American public on July 10, 2010, when he announced an overhaul in the Department of Veterans Affairs system for disability evaluations to make it easier for combat veterans to receive “service-connected” disability ratings for PTSD. “We are a nation at war,” Obama stated.

For the better part of a decade, our men and women in uniform have endured tour after tour in distant and dangerous places. Many have risked their lives. Many have given their lives. And as a grateful nation, humbled by their service, we can never honor these American heroes or their families enough. Just as we have a solemn responsibility to train and equip our troops before we send them into harm’s way, we have a solemn responsibility to provide our veterans and wounded warriors with the care and benefits they’ve earned when they come home.  

Further, elaborating on these “wounded warriors,” the president stated that

Too many suffer from the signature injuries of today’s wars: Post-Traumatic Stress Disorder and Traumatic Brain Injury. And too few receive the screening and treatment they need. Now, in past wars, this wasn’t something America always talked about. And as a result, our troops and their families often felt stigmatized or embarrassed when it came to seeking help. Today, we’ve made it clear up and down the chain of command that folks should seek help if they need it. In fact, we’ve expanded mental health counseling and services for our vets…

What is notable about the language here, which is not unique to this speech and which reveals less about Obama’s own views than about the rhetoric expected of any U.S. president in relation to veterans’ issues, is the explicit linking of PTSD, honored as

52 Ibid.
one of the two “signature injuries” of the wars in Iraq and Afghanistan, with the moral
duty of the nation to honor and to care for “wounded warriors.” PTSD has become, in
political aspiration if not always in reality, a badge of combat heroism.

All of this, however, is a very long way from the work of Sarah Haley, Chaim
Shatan, and particularly Robert Jay Lifton. Recall that for them, insofar as they used the
term at all, “Post-Vietnam Syndrome” was to be distinguished from existing models of
war neurosis specifically in that it was not neurotic: Post-Vietnam Syndrome was indeed
a wound, or at least a woundedness, but it was a wound which signified not disorder of
the veteran but rather the disorder and injustice of the war in Vietnam. It was not the
“antiwar warrior,” but rather the war itself, which was insane. We may recall as well that
Lifton worried in 1974 about the “technicization” of post-combat experience:

Put simply, American culture has so technicized the idea of psychiatric illness and
cure that the psychiatrist or psychoanalyst is thrust into a stance of scientifically
based spiritual omniscience – a stance he is likely to find much too seductive to
refuse entirely. Anointed with both omniscience and objectivity, and working
within a market economy, his allegedly neutral talents become available to the
highest bidder. In a militarized society they are equally available to the war-
makers.\footnote{Lifton, \textit{Home from the War}, 423.}

The technicist model in psychiatry, Lifton continues, entails that “a machine, the mind-
body function of the patient, has broken down,” and another machine, this time the
psychiatrist, is called upon to “treat” the first machine. Being technical, however, the
process “has nothing to do with place, time, or individual idiosyncrasy. It is merely a
matter of being a technical-medical antagonist of a ‘syndrome’ or ‘disease.’”\footnote{Ibid.}
We are left, then, to ask: could the diagnostic category that Lifton helped birth have enabled, in the hands of others, just the technicization of post-combat experience that he feared? Could, that is, the embrace of PTSD as mental disorder in DSM-III have effaced the conviction, so dear to Lifton and his early colleagues, that there was in Post-Vietnam Syndrome, as Lifton wrote in 2005, “considerable wisdom in the form of rejection of the war itself, of both its methods and its ostensible purposes?”

Could the re-narration of post-combat experience as “symptoms” lead to more intense focus on “treatment” of the symptoms (i.e., through medication) than removal of the cause of the symptoms (i.e., the Iraq or Afghanistan war, or war in general)? Could the moral energy channeled into providing care and resources to “wounded warriors” with PTSD effectively sublimate (at least some) public anxiety about the consequences of the current wars? And could all of this serve the purposes of the military and the war effort?

These are important questions which do not easily lend themselves to empirical argument, and I do not wish to state the case too strongly. There is no doubt that attention to combat-related PTSD within the military, within the media, and within the culture at large brings focus to the psychological and moral cost of war which would not exist otherwise, as documentary efforts such as the 2006 film The Ground Truth, which combines detailed interviews with Iraq war veterans and evocative footage of boot camp and the combat theater, amply demonstrate.

It is also clear that PTSD does not hide its cultural/environmental context nearly to the extent that its immediate precursor in

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American psychiatry, “war neurosis,” did, in which post-combat suffering was assumed to relate more to unresolved psychic conflicts disclosed by war than to the moral/psychological context of combat itself. (This is not a settled point within modern trauma research; a number of trauma clinicians and researchers have argued that PTSD fails to attend properly to the PTSD sufferer’s experience before and after the “traumatic event.”57 But that is beside the point here.) PTSD, in other words, is not “Post-Vietnam Syndrome,” but it bears sufficient vestiges of it so as to continue to bear some of the function imagined for the latter diagnosis by its anti-war architects. Despite this, however, I wish to offer two observations which, though not conclusive, provide supporting arguments for my concern that PTSD as a diagnosis improperly neglects the moral/social context of the suffering person.

First, PTSD is constructed in DSM-III and beyond in such a way as to efface and to render nearly unintelligible the important question of the relation of the agency of the person to the “traumatic event.” DSM-IV, we may recall, defines the traumatic event as a situation in which (1) “the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others,58 and in which (2) “the person’s response involved intense fear, helplessness, or horror.” The passive construction of these sentences would lead an unassuming reader, e.g. a neophyte clinician, to expect that the actions of the traumatized person had little to do with the fact that he or she happened to experience,

57 Bodkin et al., “Is PTSD Caused by Traumatic Stress?”
witness, or be confronted with the trauma. But this is, in many of the complicated and broken situations which retrospectively become labeled “traumatic events,” much too simple. Although there are certainly plenty of cases in which the traumatic event is indeed entirely or nearly entirely passive, outside any agentic control of the traumatized person (one thinks here of many rapes, sudden automobile accidents, bystander witnesses of violence, and so on), it is nonetheless also true that much of the time the agency of the person is relevant, perhaps even causally relevant, to the character of the situation as “traumatic.” This is perhaps especially true of combat trauma, in which traumatic events often involve a soldier’s decision to use particular kinds of lethal force in stressful and perhaps confusing wartime situations. As Haley, Lifton, and Shatan well understood, the suffering of the Vietnam veteran frequently had to do with “what I did over there” as much as what he or she passively witnessed. But Lifton in particular, in his evocative portrayal of the “atrocity-producing situation,” was careful not to presume a Pelagian “either/or” approach to agency, in which either the soldier is presumed to bear full responsibility for his actions, free of contextual constraint, or is entirely excused from responsibility.

Remarkably, however, the massive body of literature on trauma after PTSD became part of the *DSM* nomenclature has largely neglected what MacNair (2001) refers to as “perpetration-induced traumatic stress.”⁵⁹ Despite the existence of ample qualitative literature suggesting that combat veterans with PTSD struggle with memories of things

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that they did in combat and of multiple quantitative analyses which have concluded not only that killing and/or participation in “atrocities” is a risk factor for PTSD but also that it often predicts more severe and chronic PTSD symptoms, perpetration-induced traumatic stress remains, on the whole, an underdeveloped segment of the trauma research literature.

This relative neglect of the role of agency in the context of the traumatic event is linked to a second observation, that PTSD as a diagnostic category has enabled the development of a whole category of treatments, including psychotherapeutic treatments, which are essentially technical interventions designed to reduce the severity of specific, quantifiable PTSD symptoms and which are only secondarily concerned, if at all, with the moral context in which trauma is experienced. Many clinicians and researchers would not see this as a problem. PTSD, after all, has been included in the DSM as a mental/psychiatric disorder and so it is only appropriate that researchers should attempt to find effective treatments for it. This research, like most contemporary psychiatric treatment research, takes a specific form. First, various standardized, quantitative rating scales are developed which measure the severity of the PTSD symptoms identified in the DSM (numbing, avoidance, reexperiencing, and so on). Quantitative treatment trials are

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then designed and executed in which part of a patient population receives an investigational therapy (e.g., a medication or a psychotherapeutic intervention) and part receives either no therapy or, more likely, a different investigational therapy or supportive care only. Therapeutic interventions which result in statistically significant improvement in PTSD scores, relative to controls, are then considered empirically validated, particularly if this benefit is replicated in subsequent studies. Though the evidence generated by this body of research is mixed and is a subject of current vigorous debate among trauma clinicians and researchers, there is general (though not unanimous) consensus that some medications, particularly the serotonin-selective reuptake inhibitors, confer some therapeutic benefit for reduction of PTSD symptoms and even more consensus that some psychotherapeutic approaches, particularly exposure therapies, are effective.62

.. Structuring clinical research in this way, however, entails positivist interpretive commitments. Specifically, in order to belong to the class of “effective treatment” or “evidence-based treatment,” a particular therapy must lend itself to quantitative measurement, must be amenable to standardized implementation (e.g., by use of a clinical treatment manual giving scripted week-by-week approaches to the therapy), and must be time-limited. But quantitative measurement nearly always includes measurement of symptoms, so that the criterion of success of the therapy is quantifiable reduction of symptoms. In this framework it is symptoms, and not the complex social and

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interpersonal reality underlying the symptoms, which become the organizing focus of treatment. If the most effective and efficient way to reduce symptoms is to attend to this broader social/political/moral traumatic context, then the logic of clinical research would recommend this approach; but conversely, if a particular therapy could reduce symptoms without addressing these larger questions, all the better. Using this logic, contemporary trauma clinicians and researchers can describe particular PTSD therapies as “effective” without specific regard to whether or not the therapy addresses the moral context of the traumatic event.

Although the technical logic of psychopharmacology is obvious, the technical logic of “evidence-based” psychotherapy for PTSD can be demonstrated by looking at two of the most clearly effective psychotherapeutic approaches for combat trauma, Prolonged Exposure Therapy (PE) and Cognitive Processing Therapy (CPT). Both of these approaches evolve from cognitive behavioral therapy (CBT), though PE is more oriented toward stimulus-response learning theory and CPT more oriented to the cognitions underlying a traumatic event. Prolonged exposure therapy is premised on a learning theory which its creators refer to as Emotional Processing Theory, which holds that “fear is represented in memory as a cognitive structure that is a ‘program’ for escaping danger.” When the person faces a “realistic threat,” the fear is adaptive; but fear becomes pathological when relatively harmless stimuli (e.g., a can on the side of an

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65 Foa et al., Prolonged Exposure Therapy for PTSD, 12.
American highway) trigger an excessive fear response (i.e., for the Iraq veteran concerned about improvised explosive devices) and habitual avoidance of traumatic cues prevents the patient from extinguishing these learned fear responses. Prolonged exposure therapy is a program for “deliberate, systematic confrontation with stimuli” in order that the person will lay down new associations with these (non-harmful) stimuli and therefore gain control over his or her anxiety. But the standard manual for training psychotherapists to administer prolonged exposure therapy mentions “prominent guilt or shame” only in passing, noting that exposure therapy is still often “effective” for individuals who demonstrate prominent guilt and/or shame but that “we recommend that ample time be devoted to addressing the guilt. Imaginal exposure to the trauma memory will help the client to view the trauma in context and, along with the following processing, will help the client put the events in realistic perspective.”

Cognitive processing therapy, though also a variant of cognitive-behavioral therapy, stems from a “social cognitive” theory of traumatic stress which focuses, relative to prolonged exposure therapy, on the way that patients interpret traumatic events, with

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66 Ibid., 29. In the therapist training manual, the authors cite a case study in which a Vietnam combat veteran with prominent guilt/shame symptoms was effectively treated with PE. In this study, a then-52 year old Catholic white male Vietnam veteran participated in a virtual reality study in which he toured a “virtual Vietnam” under the guidance and supervision of a therapist who helped him to cope with exposure to five painful memories, which included an episode in which he fired a mortar into a village and injured a civilian in revenge for the death of a comrade. Before the course of therapy, he would (according to the investigators) vacillate between indignant and dehumanizing expression of rage toward the North Vietnamese, on one hand, and despair at his own guilt about the perpetrated acts, on the other. At the end of therapy, he “expressed concern about his victim and could appreciate her humanity and would brainstorm spontaneously about ways to help victims of war. At the end of the treatment, the participant could also focus on the sadness he felt about his lost comrade (the event which provoked the retaliatory rage) and could acknowledge that he too was victimized as a young soldier.” Barbara Olasov Rothbaum and others, “Virtual Reality Exposure Therapy of Combat-Related PTSD: A Case Study Using Psychophysiological Indicators of Outcome,” *Journal of Cognitive Psychotherapy: An International Quarterly* 17 (2003): 163-178.
the assumption that PTSD manifests itself when traumatized individuals become stuck with maladaptive cognitive interpretations of the trauma and therefore do not recover from the trauma. A major focus of CPT is therefore to explore, clarify, and sometimes to challenge patients’ interpretations of trauma. This leads therapists, perhaps reluctantly, to “issues of religion and morality.” Therapists are instructed that patients may ask questions like “How could God let this happen?,” or “Is God punishing me?,” or “Why me?” This reflects, for many patients, the “‘just world belief, . . . which is taught directly by some religions,” specifically patients’ belief that “if they follow the rules that good things will happen and that if someone breaks the rules that they will be punished.” Because no religion actually teaches that this will always be the case, however, a patient holding to the just world belief “may have distorted his religion or was taught this by a mistaken parent or religious leader.” If patients wonder how God could have let another person commit an act of violence, therapists are encouraged to introduce the concept of free will, which is a tenet of “most Western religions:”

Most Western religions adhere to the concept of free will, of choice to behave or misbehave (or what are heaven and hell for?). If God gives an individual free will to make choices, then it does not follow that He would take away the free will of another person in order to punish the patient. . . Free will implies that God does not step in and stop the behavior of others any more than He forces the patient to behave or misbehave…. If a person believes that lives are predetermined and that he has no free will, then you may wonder why he has PTSD. What is the conflict? Is he having trouble accepting his fate? Or is it a matter of not being able to process emotions?  

67 Resick, Monson, and Chard, 10.  
68 Ibid.  
69 Ibid., 11.
Therapists are also instructed that patients in CPT may raise issues of guilt and the need for “self-forgiveness.” Therapists should first, however, challenge the specifics of the event to see if your patient has anything for which to forgive herself. . . Killing someone in war is not the same as murdering someone. The person may have had no other options than what occurred at the time, so the Socratic questioning needs to establish intent, available options at the time, etc. One should only discuss self-forgiveness when it has been established that the patient had intended harm against an innocent person, that he had other available options at the time and willfully chose this course of action. Killing a civilian by accident (e.g., someone caught in the crossfire) in a war is just that, an accident. Committing an atrocity (raping women or children, torturing people) is clearly intended harm. Guilt is an appropriate response to an atrocity or committing a crime. A patient may well need to accept what he has done, be repentant, and seek out self-forgiveness, or if religious, forgiveness within the church or other place of worship.

The program of cognitive processing therapy is, like prolonged exposure therapy, a manualized, short-term therapy, generally around 12 sessions in length, which focuses on identifying thoughts and feelings associated with the traumatic event, working through “stuck points,” and arriving at alternative cognitive interpretations which result in less painful feelings in relation to the traumatic memory.

I have described PE and CPT at some length in order to demonstrate the way that “evidence-based” psychotherapy can disguise substantive moral argument under the auspices of technique, with the result that the controversially moral aspects of these treatments goes undernamed and underrecognized. Both PE and CPT have been shown “effective” for reducing PTSD symptoms in numerous well-designed randomized trials and, on that basis, have earned the respect of mental health clinicians and have gained the imprimatur of the VA (as well as other influential organizations) for treatment of combat-

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70 Ibid., 12.
related PTSD. But embedded in the technical structure of these therapies is a substantial amount of moral theology. PE, in focusing on exposure rather than on self-conscious interpretation of events, is focused on symptom reduction with no requirement that patients engage in the painful work of interpretation. CPT focused much more on cognitive interpretations, but this leads into explicitly theological concerns regarding which therapists have very little training or comfort, and the treatment manual’s recommendations for intervention are, from a Christian theological perspective, much too simplistic and individualistic. But none of these issues are either discussed with patients or discussed among policymakers when discussion arises about “effective” treatments for PTSD – it only matters, in the words of the Oxford series in which the PE treatment manual appears, that they are “Treatments That WorkTM.”

Recognizing the relative neglect of the moral context of trauma in the most prominent evidence-based psychotherapies for PTSD, a group of therapy researchers have recently begun to research the concept of “moral injury” as a “wound” of war. Litz and colleagues, in a detailed review, comprehensively survey the existing research on perpetration-induced trauma and argue that the leading cognitive-behavioral theories of PTSD, by focusing on fear rather than shame or guilt as a driving force in maintaining avoidance behavior, do not adequately account for the phenomenon of PTSD resulting from perpetrated acts. They specifically critique CPT and PE, arguing that CPT errs by assuming that “distorted beliefs about moral violation events cause misery,” when in fact

71 Foa et al., ibid.
“in the case of morally injurious events, judgments and beliefs about the transgressions may be quite appropriate and accurate.”\textsuperscript{73} PE may be inadequate, they argue, because exposure to memory of a perpetrated act without a “strategic therapeutic frame” for correcting false appraisals and for fostering positive experiences outside of therapy would potentially harm patients. In place of these therapies, they offer a preliminary treatment model (which they hope to test in a series of clinical trials) in which patients are encouraged (a) to frankly confront the acts for which they feel guilty or shameful, (b) to explore, in a modified exposure process, “a new way to view the world and the self in it that takes into account the reality of the event and its significance without giving up too much of what was known to be good and just about the world and the self prior to the event,”\textsuperscript{74} (c) to verbalize their experience and appraisals of it to a fictional “benevolent moral authority,” as a technique for encouraging perspective-taking and self-forgiveness, (d) to modify behavior and to make reparation for the injurious act, and (e) to foster reconnection with significant relationships and meaning-systems.

There is much to be commended in the way that Litz et al. point contemporary trauma clinicians to the irreducibly moral nature of some “traumatic events” and much good sense in their theory and therapeutic proposal. It is striking, though, how even this emerging movement is situated within a therapeutic, technical model, despite the disclaimer of the authors that they “[do not] want to medicalize or pathologize the moral and ethical distress that service members and veterans may experience.”\textsuperscript{75} From the

\textsuperscript{73} Ibid., 702.
\textsuperscript{74} Ibid., 703.
\textsuperscript{75} Ibid., 696.
curious choice of the word “injury” to describe guilt and shame from perpetrated violence (the “injury” is not a physical wound but “an act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness”\textsuperscript{76}) to the concluding call for “randomized controlled trials of interventions that specifically target moral injury in veterans of war,”\textsuperscript{77} the language of the moral, perhaps despite the authors’ best intentions, is fit cleanly in a cognitive-behavioral paradigm. Whatever the authors’ personal moral inclinations, there is no way within the context of their theory to describe an atrocity, for example, as anything other than an act which violates “personal and shared familial, cultural, societal, and legal rules for social behavior, either tacit or explicit.”\textsuperscript{78} If a combat veteran were to hold, for example, that a perpetrated act were an injustice \textit{per se}, or a sin against God, the “moral injury” therapist could interpret this only immanently, as a belief of the patient which, as a belief, could have either harmful or beneficial results for the patient’s well-being. Unsurprisingly, they can only awkwardly speak of religious belief, cautiously encouraging spirituality (carefully defined as “an individual’s understanding of, experience with, and connection to that which transcends the self”\textsuperscript{79}) as a means to “transcendence,” itself described unappealingly as “not being defined by the [guilt-producing] experience, and correcting the wounds by not succumbing or being that construction of the self . . . through subsequent mindful and purposeful experience

\textsuperscript{76} Ibid., 698.  
\textsuperscript{77} Ibid., 705.  
\textsuperscript{78} Ibid., 699.  
\textsuperscript{79} Ibid., 704.
moving forward.” Patients might even be encouraged to participate in “spiritual communities (e.g., a church)” because “forgiveness within religious and spiritual frameworks is potentially instrumental in alleviating guilt, shame, and demoralization.” Religious practice becomes, like the “moral injury” therapy itself, a technical intervention.

The complicated way that PTSD as a diagnosis constructs veteran experience is poignantly displayed in a recently published autobiographical account by a veteran and former Foreign Service with significant exposure to combat-related violence in Kosovo, Iraq, Afghanistan, and the Darfur region of Sudan. Ron Capps describes his experience, while serving of Afghanistan in 2002-2003, of being tormented by memories of mangled, dead bodies from Kosovo in the late 1990s. He describes visiting a military psychiatrist and states that

as I spoke, my fear and frustration and self-loathing rolled out, and I began to cry. The psychiatrist asked some questions and we talked some more. He said he could help me. . . . Those simple words helped – I felt lighter, calmer, stronger. He said I was suffering from post-traumatic stress disorder – PTSD – and probably depression; I needed medication.

Green then describes his fear that being in mental health treatment would cause him to lose his security clearance as an intelligence officer and his discontent, after his combat tour ended, with the tedium of a State Department position in Washington. He volunteered for a State Department assignment to Iraq but then volunteered for a military deployment to Darfur, where he was again confronted with massive war-related

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80 Ibid.
81 Ibid.
83 Ibid., 1408.
suffering. Again unable to bear the relative monotony of stateside work and family life, he returned to Sudan as a Foreign Service officer where “crisscrossing Darfur, writing reports about the failing peace process and the mayhem around me, I slipped further and further into the medical disorder. I self-medicated with leftover Prozac and whisky. It wasn’t very effective.”

Green is to be commended for the courage to tell his story publicly. I cite his work not in any way to undermine or to discredit his account, but only to point out how profoundly his experience was shaped by “PTSD.” 

I needed medication. . . I slipped further and further into the medical disorder. . . I self-medicated . . . It wasn’t effective: none of these constructions are neutral, and all display the way that Green’s experience is both true and radically modern. “PTSD,” by labeling his experience, also shapes his narrative memory and therefore constructs it.

5.4 Diagnosis and the Construction of Experience

I have entered into such a lengthy analysis of PTSD to demonstrate, by way of example, that psychiatric diagnosis, in many cases, performs linguistic and moral work which far exceeds its widely acknowledged pragmatic and instrumental roles. If diagnosis were simply a linguistic tool to enable common communication between clinicians, to garner third-party clinical reimbursement, to provide a common base for scientific research, and to legitimate the use of particular technologies, a moral theologian writing about psychiatry could safely choose to ignore it, or at least to minimize its

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84 Ibid., 1409.
importance. The really important practical-moral question for Christians who wish to engage with modern psychiatry, one could then perhaps argue, is not diagnosis *per se* (which, as a straightforward description of a person’s psychological state, can be accepted without much difficulty) but rather the way that one *responds* to the assignment of a diagnosis, for example in the choice for or against medication and the choice for or against various schools of psychotherapy.

If the argument of this chapter is valid, however, then diagnosis is much more interesting, and much more powerful, than that. The cultural power of psychiatric diagnosis lies not solely in these instrumental functions but rather in its ability to construct experience, and therefore to construct the world and the self, in such a way that medical/technological response seems not only legitimate but also natural and even necessary. It can only do so, of course, as a product offered to a culture which is primed to receive it, a late-modern culture replete with all of the ambiguity and complexity and pathos of any human culture but lacking much in the way of either theological anthropology or ascetical theology\(^85\) and fixated on the soteriological promise of medicine and “science.” To such a culture, or more precisely to individuals within such a culture, psychiatric description and diagnosis can be profoundly powerful. Inchoately painful experience becomes, in the organizing narrative of diagnosis, less inchoate and therefore, in many cases, less painful; counterproductive and meaningless behavior may be rendered meaningful and, in that context, productive. William James once described

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conversion as “the process, gradual or sudden, by which a self hitherto divided, and consciously wrong inferior and unhappy, becomes unified and consciously right superior and happy, in consequence of its firmer hold upon religious realities.” To receive a diagnosis that is true, that organizes confusing or painful experience and behavior in helpful and clarifying new ways, is to undergo a kind of late-modern conversion.

The diagnosed self, however, is already determined in very particular ways that limit the kinds of questions that are asked and the way that moral-practical deliberation is framed. Once diagnosed, for example, one may not know whether one needs pharmacotherapy or psychotherapy, but one is made fully aware to seek “therapy” of some sort. One may not know how to conceptually relate one’s mental illness to one’s spirituality or one’s religious commitments, but one is aware that one is “ill” and that this has spiritual/religious import. One may not know how to reconcile one’s symptoms with one’s most deeply held identity and commitments, but one is aware that one “has” symptoms which stand in some external-yet-internal relation to one’s truest self. One is fully bound, that is, within the conceptual horizon of the medical.

Not all conversions, of course, are to be equally lauded. Charles Taylor, notably, has argued that naturalistic and reductionist accounts of human psychology often fail, indeed must fail, because they neglect the essentially interpretive and therefore essentially moral constitution of human agency. Drawing on post-Heideggerian hermeneutical theory and the work of Harry Frankfurt, Taylor argues that “a fully competent human agent not only has some understanding (which may be also more or less

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86 William James, *Varieties of Religious Experience*, 189.
misunderstanding) of himself, but is partly constituted by this understanding,” and that furthermore this self-understanding must take the form, at least in part, of “strong evaluation,” namely evaluation which hinges on distinctions of greater and lesser worth. Humans, argues Taylor, are therefore self-interpreting animals, and this entails, under the normal conditions of human life, that agency is linguistically embedded. “We are language animals,” Taylor writes;

We are stuck with language, as it were. And through the language we have come to accept, we have a certain conception of the imports that impinge on us. This conception helps constitute our experience; it plays an essential role in making us what we are. To say that man is a self-interpreting animal is not just to say that he has some compulsive tendency to form reflexive views of himself, but rather that as he is, he is always partly constituted by self-interpretation, that is, by his understanding of the imports which impinge on him.

If Taylor is correct, then psychiatric diagnosis stands in an ambiguous relationship to human agency and personhood. On the one hand, alongside and through its nosology psychiatry provides a complex “web of interlocution,” a morally orienting space, within which human selfhood and agency can take shape. On the other hand, however, if diagnoses are reductive either in their construction or in their use (or both), discouraging accounts of a self constituted by rich moral sources and promoting the “disengaged modern consciousness” in which the self finds power and dignity precisely through detachment both from moral sources and from “expressively dead,” technically

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90 Taylor, Human Agency and Language, 5.
manipulable “nature,” then the language which seems to enliven and empower the diagnosed self simultaneously impoverishes it.

The implications for clinicians (and, correlatively, for their patients) are clear. The linguistic and conceptual work of psychiatric diagnosis far exceeds, at least much of the time, its relatively simple role in legitimating the use of psychiatric technology. Psychiatric diagnosis is not praxis-neutral; it not only legitimizes the logic of the therapeutic but also entails it. Because of this, clinicians must carefully attend not only to the straightforward instrumental implications of a diagnosis (its legitimization of particular technologies or of social benefits like disability coverage, its role in payment and in the organization of health care systems, etc.) but also to the way in which particular diagnoses, and to some degree any diagnosis, can construct the experience, and therefore the self, of the person so diagnosed.

For Christians and adherents of other religious traditions seeking to engage modern mental health practice, there are further implications. Theological engagement with psychiatry must not presume the usefulness and validity of contemporary diagnosis en route to moral/theological critique of different forms of treatment. Rather, medical description itself must be theologically interpreted: theological engagement with psychiatry must focus not only on the uses of technology and on particular modes of psychotherapy but also on the descriptive-linguistic contexts which render these uses possible. For that, however, one needs an adequate theological anthropology; and in

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91 Taylor, Sources of the Self, 148.
pursuit of *that*, we progress to the second part of this work, which examines these questions in conversation with the psychology and anthropology of St. Thomas Aquinas.
Part Two:

Thomas Aquinas, Psychiatric Nosology, and the Psychiatric Technologies:
A Philosophical and Theological Engagement
6 St. Thomas Aquinas, Contemporary Psychology, and Sacra Doctrina: A Prologue on Method

Consequatur apud te, clementissime Pater mea rationalis potential sapientiae illustrationem concupiscibilis desiderabilium adep tionem irascibilis triumphi laudem, . . .

With You, most merciful Father, may my mind attain the enlightenment of wisdom, my desire what is truly desirable, and my courage the praise of triumph . . .

Da, Domine Deus, vitam sine morte, gaudium sine dolore, ubi est summa libertas, libera securitas, secure tranquillitas, jucunda felicitas, felix aeternitas, aeterna beatitudo veritas visio, atque laudation, Deus

Give me, O Lord my God, that life without death and that joy without sorrow where there is the greatest freedom, unconfined security secure tranquility, delightful happiness, happy eternity, eternal blessedness, the vision of truth, and praise, O God.

Amen.

Amen.

--from St. Thomas Aquinas, “For the Attainment of Heaven.”

We come, at the beginning of Part Two of this work, to a marked (and, for some readers, perhaps a jarring) rhetorical transition-point. Although I described the overall aim of this work in the introductory chapter as a “Thomistic account of the Christian use

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of psychiatric technology,” neither the writings of St. Thomas\(^2\) nor, for that matter, those of any other theologian have been prominently foregrounded in the course of Part One. In these chapters, rather, I have endeavored to provide, *qua* psychiatrist, a faithful and yet critical account of contemporary psychiatry and contemporary psychiatric nosology which draws primarily from the psychiatric and philosophy-of-psychiatry literature itself, with the notable aid of particular philosophical resources such as the work of Alasdair MacIntyre. All of this has been offered with theological consideration in mind, but none of it – if I have succeeded – has required readers to enter a specifically Christian theological context in order to understand and/or to evaluate it. I have not attempted to provide a constructive theology but only to argue that there are conceptual and practical spaces within modern psychiatric theory and practice which demand commitments regarding the nature of human flourishing, commitments which are generally thought to pertain not to psychology or neurobiology but rather to moral theology and/or other traditions of normative ethics. Readers of this work will be, I suspect, split regarding this method. Some will be eager for more robust engagement with theology and with theological texts, and will perhaps welcome the methodological shift of the chapters that follow. Some, however, might have been quite comfortable with the method (even if not the conclusions) of the first chapters, and might be uncomfortable with the explicitly Christian cultural-linguistic context of Part Two. For these readers, a brief introduction to the second part is in order.

\(^2\) Thomistic scholarship variously, in different contexts, refers to the same author as “St. Thomas,” “Thomas,” or Aquinas.” I will use these names interchangeably in the remainder of this work.
The bottom-up argumentative mode of Part One is, of course, a deeply Thomistic approach, engaging and evaluating nontheological texts and empirical scientific observation as an integral component of philosophical and theological exposition and interpretation. Perhaps in part because this is the case, there is the great danger and temptation that an effort to bring Aquinas’ thought into conversation with contemporary psychology and psychiatry would not require any significant imaginative shifts. Contemporary interlocutors, interpreting Thomas as a “natural theologian,” might suppose that he would be quite supportive of contemporary neurobiological claims regarding the relationship of mind and brain and, correlativey, quite accepting of modern psychiatric nosology. In this light, Thomas could be seen as a natural ally of contemporary psychiatry against contemporary religious antipsychiatric voices who furthermore might be able to make some useful philosophical contributions of his own. Thomas’ insistence that the passions are always about something, for instance, could be seen as a helpful contribution to modern emotion theory. Thomas’ Aristotelian appropriation of the tripartite soul might be seen as a helpful way to narrate the relationship of human with non-human animal cognition. Perhaps most usefully, Aquinas might be seen as the most articulate medieval expositor of a virtue theory of ethics, unduly neglected within contemporary biomedicine, which might be reconfigured for the needs of contemporary practitioners and applied to modern clinical practice.


There is nothing wrong with mining the work of Aquinas, or of any other thinker, for helpful conceptual resources; but to do only this would be to miss much of the richness and beauty of Thomas and his world. St. Thomas’ world was not at all the world of contemporary neurobiology, psychology, and psychiatry, and not only because he died 600 years before Wundt, James, Kraepelin, and Freud began their seminal work.

Entering into St. Thomas’ world, which Thomas would have gladly named not as his world at all but as the world graciously provided by God to him and to fellow viatores (“wayfarers”), requires not only historical reconstruction, which is difficult enough, but also a kind of theological imagination which is attuned to the beauty that Aquinas situates uniquely in the life of God. Etienne Gilson, for example, writing of Thomas’ teaching that God is infinite and therefore present in all things, states that

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\text{Hence the Thomistic universe even on the plane of metaphysics takes on the appearance of a sacred universe. . . The Thomistic universe is a world of beings, each one of which gives testimony to God by the very fact that it is. All things therein are not of the same rank. There are glorious beings like the angels, noble ones like men, and more modest beings like beasts, plants and minerals. Of all these beings there is not one which does not bear witness that God is the supreme act-of-being. Like the highest of the angels, the humble blade of grass bears this resemblance to God. The world of St. Thomas is one where it is a marvelous thing to be born. It is a sacred world, one impregnated to its every fibre with the intimate presence of a God whose supreme actuality preserves it in its own actual existence.}^5
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To think with Thomas, therefore, is to think as a theologian, for Thomas was first and foremost a theologian; he was not a scientist at all and engaged in philosophy, at least in the later work of the Summa theologiae, only insofar as philosophical analysis served

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both to confirm the truth of, and to guide human understanding of, his theology. The world of St. Thomas is therefore unintelligible apart from the God who stands both as its sustaining cause and as its final end; who created a world of good things directed to God’s glory; who uniquely gifted human beings with the faculty by which humans could, in grace, apprehend the truths of God and order their lives by God’s ends; and who, when sin threatened the possibility of this ordering, provided the way back through the incarnation, death, resurrection and ascension of the uncreated word, Jesus Christ. To regard human life ad mentem sancti Thomae is to view life in this larger teleological-soteriological horizon. It is, in fact, to adopt a Christian view of life.

This specifically Christian interpretation of the world is not explicitly entailed by my argument in the first part of this work, and this too is a Thomistic principle. Contrary to common misconception, Thomas did not hold that all doctrine essential to Christian faith, sacra doctrina, could be derived by philosophical or scientific argument. In the very first article of the Summa theologiae, he argues that a revealed knowledge of divine things, excessive of any philosophical argument, is necessary, and this for two reasons: because without divine revelation, humans would not have understood God (who exceeds human reason) as their final end; and because even “the truth about God such as reason could discover, would only be known by a few, and that after a long time, with the admixture of many errors.” Although some truths about God can be known, Thomas

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6 Ibid., 6.
7 Thomas Aquinas, Summa Theologiae Ia q. 1 a. 1 resp. Hereafter, the title will be abbreviated as STh, followed by customary citations. All quotations from the Summa theologiae, unless otherwise noted, are from the translation of the 1911 translation of the Fathers of the English Dominican Province: St. Thomas Aquinas, Summa Theologica, 5 vols., trans. by Fathers of the English Dominican Province (New York: Benziger Bros., 1948; reprint, Notre Dame, Ind.: Christian Classics, 1981). I chose to refer to the 1911
holds, through philosophical argument (e.g., God’s existence, God’s perfection, and God’s unity), other truths of God’s nature (e.g., God’s being as trinity) can only be known through revelation. Indeed, the truths of *sacra doctrina* cannot properly be derived via argument, and disputation about the truths of *sacra doctrina* can occur “only if the opponent admits some at least of the truths obtained through divine revelation.”

This holds even in Thomas’ widely cited (and commonly misunderstood) arguments for the existence of God. Rejecting both St. John Damascene’s argument that the knowledge of God is innate within human experience and St. Anselm’s “ontological proof” for God’s existence, Thomas argues rather that God’s existence can be proved through *a posteriori* consideration of God’s effects (*quia* argument rather than *propter quid* argument). Proposing five such effects which demand various kinds of causal account, Thomas ends each argument with the conclusion that a particular perfection must exist
(first mover, first efficient cause, uncaused necessity, perfect goodness, intelligent designer) and then asserts that, to quote the construction of the first argument, “hoc omnes intelligunt Deum [this everyone understands to be god].”\(^\text{12}\) That these causal perfections can be shown to exist is, for Aquinas, a matter of philosophical demonstration (quia); that these perfections are called “God” is a matter of linguistic and social convention; but that the first efficient cause is the Triune God, the God of Abraham, Isaac, and Jacob, is not a matter for philosophical argument but rather for revealed sacra doctrina. The “this,” in other words, is a matter of demonstration; but that “this” is the God of Abraham, Isaac, and Jacob, is not demonstrated but rather revealed.\(^\text{13}\)

Some readers may worry that, having led them through five chapters of immanent, nontheological argument, I am now veering into a sectarian fideism which has little to do with modern psychiatry or psychology and certainly has nothing constructive to offer to either discipline. But St. Thomas is too nuanced, too careful, too eager to engage in philosophical complexity, to be dismissed in that way. It is true, of course, that sacra doctrina and the theological virtue of faith are requisite for any analysis which purports to be Christian; and it is also true, as MacIntyre’s work demonstrates, that practical reasoning, including that of contemporary psychiatric nosology, emerges from and contributes to the concrete needs of particular moral communities. From the perspective of those constrained within the modern fiction that rationality must be a-

\(^\text{12}\) STh Ia q. 2. a. 3. resp.

\(^\text{13}\) See Rudi te Velde, Aquinas on God: The ‘Divine Science’ of the Summa theologiae (Burlington, Vt.: Ashgate, 2006), 44-47, who argues convincingly that the “five ways” must be interpreted in the context of Thomas’ larger theological project in the Summa, and Fergus Kerr, After Aquinas: Versions of Thomism (Malden, Mass.: Blackwell, 2002), 52-72, who describes the Five Ways as “the first lesson in Thomas’s negative theology” (58). See also Shanley’s commentary on this text (already cited above), 191-192.
communal and ahistorical (a fiction which, as we will see, poisons many modern attempts to interpret Aquinas’ treatment of the human intellect), such an account might indeed appear sectarian and fideistic. But Thomas distinguished himself in his own time as a careful and often sympathetic interpreter of pagan, Jewish, and Muslim scholarship and, even more controversially, as a champion of empirical observation and inductive argument, and for three reasons – which we might broadly classify as ontological, epistemological, and historical – he deserves close attention by anyone interested in the critical engagement of theology with the healing arts who is also concerned that the texts and practices of both are treated fairly. Each of these three themes is well-traveled within Thomistic scholarship, and I will only briefly touch on each of them here.

First, on an ontological level, St. Thomas was a great advocate of the unity of truth. Contrary to other medieval thinkers in his era such as Siger of Brabant, who famously held that the truths of revelation could contradict the truths of reason and of philosophy, Aquinas held that *sacra doctrina* cannot contradict the truths of reason and science, properly understood, since all truth, understood as the conformity of a thing with a knowing intellect, is unified in the One who is Truth. For that reason, Thomas holds that even when the shared presuppositions necessary for proper theological argument are lacking, *sacra doctrina* can still be useful for correcting misconceptions of opponents, since “the contrary of a truth can never be demonstrated,” and therefore “it is clear that the arguments brought against faith cannot be demonstrations, but are difficulties that can

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15 *STh* Ia q. 16 a. 1 *resp.*, Ia q. 16 a. 5 *resp.*, Ia q. 16 a. 8 *resp.*
be answered.”

Furthermore, Thomas clarifies that *sacra doctrina* freely makes use of the work of philosophers (considered as extrinsic and probable arguments) who are able to apprehend truth though the use of natural reason.

This stance toward natural reason allows Aquinas to explore and to celebrate the gifts of philosophy and empirical science without conflating their methods with that of *sacra doctrina* proper. Philosophy and natural science are not infallible methodological guides to truth – Thomas twice in his discussion of truth in the *Prima Pars* quotes Ps. 11:1, *diminutae sunt veritates a filiis hominum* (“truths are decayed among the children of men”) – and therefore must be normed and tested against the truths of *sacra doctrina*. But the claims of philosophy and natural science demand, within Aquinas’ system, serious reckoning; and disputed claims demand engagement and response, not *a priori* dismissal.

Second, St. Thomas’ Aristotelian emphasis on the epistemological priority of sense-knowledge encourages, as it did for Aristotle, active investigation of phenomena in the natural world. Following Aristotle, Aquinas holds that the senses take on a thing’s species without taking on its matter, “just as wax receives the ring’s seal without the iron and gold,” and that whereas a thing’s form has natural being in the sense object, it has

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16 *STh* Ia q. 1 a. 8 *resp.*
17 *STh* Ia q. 1 a. 8. *ad2.*
intentional or spiritual being in the sense.\textsuperscript{19} It is this sensory information, as we will examine in more detail in the next chapter, which becomes the object of the integrative perceptual powers of the estimative sense, the common sense, and \textit{phantasmata}, from which, in turn, the agent intellect abstracts universal forms. In this way, for Aquinas, intellectual knowledge is derived from sensory things,\textsuperscript{20} the intellect cannot derive intelligible species without turning to the phantasm produced by sensation and perception,\textsuperscript{21} and the judgment of the intellect is rendered untrustworthy in the absence of sensory function.\textsuperscript{22}

All of this rendered Aquinas, the pupil of the pioneer experimental biologist Albert the Great, highly sympathetic to what would today be referred to as empirical science. G. K. Chesterton, in his schematic but rhetorically vivid sketch of St. Thomas, states that “[Aquinas] did not, like a modern specialist, study the worm as if it were the world; but he was ready to begin to study the reality of the world in the reality of the worm. His Aristotelianism simply meant that the study of the humblest fact will lead to the study of the highest truth.”\textsuperscript{23} This was rooted, Chesterton argues, in Aquinas’ understanding of incarnation:

There really was a new reason for regarding the senses, and the sensations of the body, and the experiences of the common man, with a reverence at which great Aristotle would have stared, and no man in the ancient world could have begun to understand. The Body was no longer what it was when Plato and Porphyry and the old mystics had left it for dead. It had hung on a gibbet. It had risen from a tomb. It was no longer possible for the soul to despise the senses, which had been

\textsuperscript{20} \textit{STh} Ia q. 84 a. 6
\textsuperscript{21} \textit{STh} Ia q. 84 a. 7.
\textsuperscript{22} \textit{STh} Ia q. 84 a. 8.
the organs of something that was more than man. Plato might despise the flesh; but God had not despised it. The senses had truly become sanctified; as they are blessed one by one at a Catholic baptism. ‘Seeing is believing’ was no longer the platitude of a more idiot, or common individual, as in Plato’s world; it was mixed up with real conditions of real belief.  

Third and finally, on a historical level, Aquinas demonstrates in his work a deep sympathy and faith (misplaced faith, as it turns out) with the biological science and medical practice of his time. Living and writing in the thirteenth century, Aquinas had very little knowledge of neuroanatomy and no knowledge of contemporary neurophysiology or neuropathology. Neurotransmitters and second-messenger pathways and the genome were unknown and unknowable to him. But when he did have the chance to engage the most advanced medical theory of his time, the medieval continuation of the Hippocratic-Galenic four-humor theory, he embraced it and incorporated into his theological-psychological analysis. St. Thomas’ theory of psychopathology, insofar as he had one, will be covered in much more detail in Chapter 8, but a single example from his treatment of the passions in the Prima secunda may help to illustrate this point. Considering whether sorrow (tristitia) is more harmful to the body than other passions such as love, joy, desire, fear, and despair, he argues that this is indeed the case:

Of all the soul’s passions, sorrow is most harmful to the body. The reason of this is because sorrow is repugnant to man’s life in respect of the species of its movement, and not merely in respect of its measure or quantity, as is the case with the other passions of the soul. For man’s life consists in a certain movement,

24 Ibid., 109.
25 This treatment appears throughout synthetic texts such as the Summa theologiae, as we will examine further, and also in some specialized treatises which Thomas wrote on exclusively scientific topics, e.g. De mixtione elementorum [On the Mixture of the Elements] and De motu cordis [On the motion of the heart]; Jean-Pierre Torrell, O.P., Saint Thomas Aquinas: Volume 1: The Person and His Work, rev. ed, trans. Robert Royal (Washington, D.C.: Catholic University of America Press, 1996; reprint, 2005), 213-214.
which flows from the heart to the other parts of the body: and this movement is befitting to human nature according to a certain fixed measure.\textsuperscript{26}

All of the passions, he explains, involve both movement of appetite (their formal element) and bodily transmutation (their material element). Because all of the passions involve bodily change, they can be harmful to the body in two ways: by hindering the natural healthy movement of the humors, or conversely by quantitatively overwhelming them. Passions of pursuit such as love, joy, and desire can harm the body not by hindering healthy humoral flow but by overwhelming it (as when, we might say, someone is so overcome with joy that they grow faint). But passions of retreat such as fear, despair, and sorrow are “simply harmful” because they effectively hinder the progress of the healthy humors – and sorrow, which “depresses the soul by reason of a present evil,” is most harmful of all.\textsuperscript{27}

The humoral physiology on which Aquinas bases this argument is, from the perspective of modern biology and medicine, simply wrong. Readers concerned about the subordination of biology to theology, however, should be reassured that Thomas placed a sufficiently high value on the medicine of his time so as to have the opportunity to be wrong. Thomas’ fault, if anything, is not that he was pre-emptively dismissive of scientific or medical theory but rather, as I will argue in chapter 8, that he gave it credence which it simply did not deserve, in that the four-humor theory was no better at grounding psychiatric nosology than is its contemporary neurobiological descendent. Even more notable, is how much Thomas got right in contemporary perspective, with the

\textsuperscript{26} STh IaIIae q. 37 a. 4 resp.  
\textsuperscript{27} Ibid.
aid of his metaphysics, while working with a wrong theory of physiology. Even in this example we see evidence of a non-Cartesian theory of emotion in which activity of the soul is also, as matter to form, activity of the body. Rejecting the argument that sorrow has spiritual but not physical existence, and therefore cannot harm the body, Aquinas argues that “the spiritual movement of the soul is naturally the [formal] cause of bodily transmutation.”28 We also see evidence of a detailed taxonomy of emotion which rivals, in nuance and complexity, anything found in the contemporary psychology of emotion.

I have chosen St. Thomas as a theological guide for Part Two of this work precisely because of the care and nuance with which he approaches empirical biology. Thomas is a theologian who is both committed to sympathetic and fair engagement with empirical science and committed not to forget that the proper object of theology is not the natural world but, properly, God. To the physician and natural scientist trapped within the methodological myopia of contemporary biomedicine, Thomas issues something of an invitation. Keep your love of observation and experiment, he says. Keep your delight in discovering new things and your commitment to serve those who suffer. Keep all of those things – but now regard yourself within a wider and more wondrous horizon, more expansive than you ever dreamed possible. See the world of things not as expressively dead “nature”29 but rather as Creation which proclaims the glory of its creator. See the body you treat not as a vehicle in which a person attempts to manufacture meaningful

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28 STh IaIIae q. 37 a. 4 ad1.
existence out of meaningless matter but rather as the locus in which humans are able to apprehend and to order their lives to the good things of God, having been rendered so by the God-man who, in the body, conquered death itself. See human emotion not as a tangled web of neurotransmitters, stress hormones, and receptors but rather as the inscription in the body of the soul’s desire to pursue the good and to avoid evil, intelligible along the lines of those pursuits. See life itself not as a necessary but always failing struggle against inevitable mortality but, excessive of this, as a journey of wayfarers toward the One who, having triumphed over death, is their ultimate destination and final happiness. Above all, see beauty: not the kind of transient beauty which arises from the temporary gratification of desire but, rather, the stable yet dynamic beauty which resonates within the harmonious order of things in God. Again, Chesterton:

Alone upon the earth, and lifted and liberated from all the wheels and whirlpools of the earth, stands up the faith of St. Thomas . . . , vitally and vividly alone in declaring that life is a living story, with a great beginning and a great close; rooted in the primeval joy of God and finding its fruition in the final happiness of humanity; opening with the colossal chorus in which the sons of God shouted for joy, and ending in that mystical comradeship, shown in a shadowy fashion in those ancient words that move like an archaic dance; ‘For His delight is with the sons of men.’

The call of St. Thomas, in our time at least, is not one of coercion but of persuasion and of aesthetic invitation.

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7 ‘Endow My Body With Beauty of Splendor . . .:’ Aquinas and the Eschatological Body

Te Deum totius consolationis invoco, God of all consolation,
qui nihil in nobis You Who see nothing in us
praeter tua dona cernis but what you have given us,
I invoke your help:
ut mihi post hujus vitae terminum after this life has run its course,
donare digneris grant me
cognitionem primae veritatis knowledge of you, the first Truth
fruitionem divinae majestatis. and enjoyment of your divine majesty.

Da etiam corpori meo, largissime remunerator, O most bountiful Rewarder, endow
claritatis pulchritudinem, my body
agilatatis promptitudinem,
subtilitatis aptitudinem,
impassibilitatis fortitudinem.
Add to these
affluentiam divitiarum
influentiam deliciarum
confluentiam bonorum,
So that I may enjoy
ut gaudere possim
 supra me de tua consolatione
infra de loci amoenitate
intra de corporis et animae glorificatione
and the sweet companionship
within me,
juxta de Angelorum et hominum delectabili associatione. . .
and of men and angels around me. . .

--from St. Thomas Aquinas, “For the Attainment of Heaven.”

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7.1 What Might Aquinas Offer to Contemporary Philosophy of Psychiatry, and What Difference Does This Make for the Use of Psychiatric Technology?

Biological psychiatry, and by extension much of contemporary clinical psychiatry as a whole, is an essentially and inherently pragmatic discipline, borne of the practical exigency of caring for the inmates of the nineteenth-century asylum and then, later, for outpatients who sought the psychiatrist’s help for various forms of distress. As such, as shown in Part One of this work, psychiatrists often do not reflect on the basic philosophical commitments of their work unless these sorts of distinctions are demanded by the needs of their practice; and apart from certain forensic and legal practice settings, this tends not to happen very often. When it comes to basic questions in the philosophy of mind – the relation, for example, between mind and brain, or between reason and emotion – most psychiatrists can and do get along in everyday clinical practice with vaguely settled commitments which, at least in the United States, are only rarely forced to detailed articulation. Although nearly all psychiatrists and neurobiologically-oriented mental health clinicians take it as settled orthodoxy that Descartes’ substance dualism has been thoroughly discredited by contemporary neuroscience, and that therefore brain and mind are related in some intimate way, pragmatic utility generally trumps philosophical precision. Since somatic interventions such as psychotropic medications (and other substances) unquestionably affect cognition, emotion, and will, psychiatrists accept some form of bottom-up affectation of mind states by brain states. Since psychotherapeutic treatments appear to affect not only behavioral and emotional patterns but also patterns of neural networks, psychiatrists generally accept some form of “top-down” influence of mind on brain. That is about as far as most psychiatrists in clinical practice are willing to
This is too bad, because if the argument of Part One is sound, the philosophical presuppositions which both patients and clinicians bring with them into the clinical space matter a great deal for the way that experience is narrated and constructed and for the way that psychiatric technology is evaluated. Modern psychiatric practice is awash in un-narrated and unrecognized philosophical commitments.

When articles touching on issues in philosophy of mind have been published in major clinical psychiatric journals (as opposed to specialty publications such as *Philosophy, Psychiatry, and Psychology*, circulation 270 in 2010, for those clinicians and philosophers who wish to press the questions further), they have tended to follow the pragmatic demands of clinical care.\(^2\) Kenneth S. Kendler’s 2005 article “Toward a Philosophical Structure for Psychiatry,” published in the flagship *American Journal of Psychiatry*, is one such paper, written by a philosophically informed clinician/researcher in order to allow psychiatrists to “maximally use” the “new information” being provided to psychiatry by neuroscience and molecular biology.\(^3\) Kendler sets out to propose a “coherent conceptual and philosophical framework for psychiatry” consisting of eight propositions. First, Kendler writes, psychiatry is “irrevocably grounded in mental, first-person experiences,” and therefore must reject any form of reductionism which would deny or ignore subjectivity. Second, though individual psychiatrists, for “personal or religious reasons,” may continue to advocate for a mind-body dualism, “it is time for the

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\(^2\) A MEDLINE literature search for all journal articles with “philosophy” in the title or keyword published between 1990-2010 in the major English-language psychiatric research and clinical journals (*American Journal of Psychiatry, British Journal of Psychiatry, Archives of General Psychiatry, Journal of Clinical Psychiatry, Neuropsychopharmacology, Biological Psychiatry*) returned only 59 entries, of which only 25 (1.25 articles/year) were distinct philosophically-oriented articles. Search conducted December 19, 2010.

field of psychiatry to declare that Cartesian substance dualism is false,” and correlatively
(for Kendler) to “accept monism, the view that mental and physical processes are both
reflections of the same fundamental stuff.” The mental and the biological, in this view,
“become different ways of viewing and/or different levels of analysis of the mind-brain
system.” Third, however, epiphenomenalism, the view that “the mental world is without
causal efficacy,” seems false to ordinary experience and should be discounted (Kendler
defers further argument for this point). Fourth, therefore, psychiatrists should accept the
reality of both mind-to-brain and brain-to-mind causality. Fifth, “big, simple
neuropathological explanations for psychiatric disorders” are largely nonexistent and
searching for them is largely a waste of time; rather, psychiatrists should hope for “lots of
small explanations, from a variety of explanatory perspectives, each addressing part of
the complex etiological processes leading to disorders.” In place of grand unifying
psychopathological theories, psychiatry should embrace “explanatory pluralism” rather
than biological reductionism, embracing analysis at multiple levels of explanation
(molecular, interpersonal, and so on) and even distinguishing between “how” questions
and “why” questions (though Kendler does not show awareness of the Aristotelian
history of this distinction). This pluralism, however, should not be merely “compatible”
but rather “integrative,” in which “active efforts are made to incorporate divergent levels
of analysis” (Kendler cites as an example the incorporation of traumatic stress into
neurobiological research models of depression). The historically divergent disciplines of
psychiatry (psychoanalysis, biological psychiatry, and so on) should agree to evaluate
their methods on “the power of [their] designs, the replicability of the results, and their
relevance to understanding the causal pathways to psychiatric disorders,” which will hopefully foster, over time, “piecemeal integration” of different psychiatric disciplinary models.⁴

I have narrated Kendler’s arguments in some detail not to critique them in any detailed way (Kendler is writing for clinicians and researchers in a psychiatric clinical journal, not for philosophers and certainly not for theologians, and so it would not be fair to critique the paper’s lack of precision in philosophical argument as if he were writing for a more specialized audience) but rather to demonstrate the kind of formal characteristics that any “conceptual framework for psychiatry” useful to Christians will display. What kind of philosophical engagement of psychiatry, that is, is essential for practicing psychiatry and/or for partaking of psychiatric technology in a conceptually coherent way?

Kendler rightly points out that any coherent account of psychiatric practice must engage the relationship between the mind and the body, if only because modern habits of thought are still formed by Cartesian mind/body substance dualism. This is because mind/body substance dualism, whatever its merits for Descartes in securing knowledge of self and God amid a mechanistic universe, is pragmatically useless for psychiatry, rendering mundane and commonplace phenomena like the effect of antidepressant or antipsychotic drugs into philosophical conundra. Any conceptual account of psychiatric practice must therefore at least account for the manifold observation that particular brain

⁴ Ibid.
states are correlated, at least some of the time, with particular mental states. Kendler, in positing a nonreductive monism, attempts to provide this.

Also essential is some account of the nature of psychiatric causal explanation, which Kendler rightly takes as a subject in his analysis. What kind of account, that is, could serve as a sufficient description of how a particular disorder comes to inhere in a particular person? Kendler’s nonreductive monistic position, in which neurobiological processes can be affected by “top-down” causation, clears the way for him to posit an “explanatory pluralism” in which accounts at different conceptual levels can be entertained.

What is conspicuously missing in Kendler’s account, which in fact must be missing from any account which attempts to give a philosophical ground to psychiatry in its current political, economic, and professional configuration, is any normative account of how either the relationship of mind and brain or of causal explanation should guide the application of psychiatric technology. What is missing, that is, is ethics – not the procedural ethics which considers, for example, whether an involuntarily committed depressed patient can be forced to take medication, but rather the much more basic normative ethics which asks whether a patient who is depressed should take a medication at all. That the latter question will seem to most readers to be a straightforward clinical question and not properly an ethical question is itself indicative of the unfortunate fact that contemporary medicine has all too often relegated “medical ethics” to the ghetto of dilemma ethics (invoked only when two clinicians, or more often the patient and clinician, disagree about the appropriate course of medical care) without remembering the
Aristotelian insight that all decisions about *praxis*, insofar as they habituate the decider in virtue or in vice and (correlatively) affect the flourishing of the *polis*, are *eo ipso* ethical decisions. All clinical questions are in some respect ethical questions, and some of the most basic and mundane clinical questions – like “should I take this medication?” – are sometimes the most ethically interesting.

Although, as I have argued in Chapter 4 of this work, contemporary psychiatric diagnosis carries unexamined and therefore unnamed teleological assumptions about the proper function of the human person in his/her social context, clinical questions cannot be named as ethical questions within contemporary psychiatry because psychiatrists generally do not share with their patients (however much they implicitly assume) the kind of teleological understanding of the body which would be necessary to understand everyday clinical decisions as ethical decisions. Decisions to partake of various forms of psychiatric technology are framed (in a way underwritten by “autonomy”-based medical ethics) as matters of individual patient preference; what matters is not so much what an individual chooses as that he or she chooses whatever he or she chooses in an informed and unforced way. The only narrative against which the patient’s choice can be normatively compared is the narrative that the patient has adopted for herself or himself, such that mental health clinicians are expected (not least by patients) to help their patients/clients to determine “what is right for you” without any supposition that the clinician might provide insight into what is right *per se*.  

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5 This is not, of course, completely reflective of clinical practice, in that psychiatrists are often far more paternalistic than this account would suggest. A psychiatrist who accepts with a shrug a severely depressed but articulate patient’s decision to forego antidepressant medication in favor of psychotherapy might
Kendler’s proposal, which is superior by far to the biological reductionist models that he is principally opposing, is in some ways an ideal framework for this modern liberal psychiatry.\(^6\) Basic and clinical research is not limited to neurobiology – “explanatory pluralism” encourages psychological and even sociological investigation as well – but the biological is in no way limited. Clinicians and patients *interpreting* this research, furthermore, can apply it to clinical practice however they see fit; although Kendler’s concept of “piecemeal integration” presumes that biological events can be *caused* by events at other explanatory levels (psychological, social, etc.), there is nothing in Kendler’s argument to preclude the biologization of everything and the psychologization of everything, on the ground that everything in psychiatry is somehow biological and everything psychological, with the practical result that technology is deployed whenever it is available to be used.\(^7\)

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\(^6\) Kendler’s opposition to Descartes (like my own, to follow) is a rhetorical straw-man intended to assuage reductionist critics; no one in contemporary psychiatry would seriously wish to defend Descartes, but many would wish to defend an eliminative materialism which would reduce the mind and soul to biological event.

\(^7\) Nassir Ghaemi complains of a “lazy eclecticism” within psychiatric diagnosis which ostensibly uses George Engel’s biopsychosocial model but which in fact has little ability to distinguish biological from psychological causation: “If one truly holds that all psychiatric illnesses are biological, psychological, and social (especially if one believes that they are equally all three), then it would seem to follow that everyone should receive both biological and psychosocial treatments (treatments by both medication and psychotherapy).” Nassir Ghaemi, *The Concepts of Psychiatry: A Pluralistic Approach to the Mind and Mental Illness* (Baltimore, Md: Johns Hopkins University Press, 2007), 10.
Each of the philosophical issues that Kendler names must also be addressed in any adequate account of Christian engagement with psychiatric technology, but much more is required. Specifically, a Christian account of psychiatric technology must not only address basic questions about the relationship of mind to brain and body and about the causation of painful and/or aberrant behavior or mental experience but must also address how these questions relate to the Christian patient qua Christian believer. The Christian believer, that is, understands herself or himself not only as a union (in some sense) of mind and body but also as a body-mind whose story is borne in a particular way by the story of God as revealed in Jesus Christ, and whose life has the character of a journey with a destination. If an account within philosophy of mind or within the philosophy of scientific explanation is to be useful to Christian practice, it must address how the relationship between body and mind is itself related to the journey of the believer toward God; which is also to say that any philosophical account of psychiatry adequate for Christian consideration of psychiatric technology will provide not only a descriptive psychology but also a normative ethics.

The work of Aquinas, now seven centuries old, is valuable to Christian practical thinking about psychiatric technology because it provides both a descriptive psychology and an ethics; or, more properly, because it provides a moral psychology in which neither ethics nor psychological function can be sundered from the other. Despite his lack of familiarity with modern neurobiology, Aquinas offers an account of the soul’s relation to the body which is surprisingly helpful for thinking through modern questions about the mind-body interaction and which could give rise to a philosophically interesting and
empirically faithful account of psychopathology (an account which I will only touch on in this work). Specifically, Aquinas presents a nuanced model in which the soul is neither reducible to the body (as in eliminative materialism) nor identical with it (as in other forms of monism, including nonreductive materialism) but is also not ontologically independent of it (as in Cartesian substance dualism). Aquinas’ hylomorphism allows him to claim that human psychological function, including what we understand as cognition or “thinking,” is an embodied activity, and his model can therefore readily accommodate contemporary observations in neuroanatomy, neurophysiology, and cognitive neuroscience. Unlike regnant non-dualistic models of mind and body, however, Aquinas’ insistence on the real existence (that is, the subsistence) of noncorporeal soul provides a language to speak of the real relation of the soul’s intellectual power to that which is true and of the real relation of the intellectual appetite (the will) to that which is good – both of which terminate, according to Aquinas, in God. Openness to truth and goodness, and therefore to the moral life, is therefore intrinsic, albeit in a complex way, to Aquinas’ basic psychobiological theory.

Because Aquinas’ account of ethics is dependent on his account of psychological function, and vice versa, it is not possible to jump to a Thomistic ethical account of proper use of psychiatric technology without first understanding his psychology.

Furthermore, if one holds an account of psychological function different from that which

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8 As we will explore in this chapter, soul (anima) for Aquinas is not precisely what modern philosophers mean by “mind.” It is rather, following Aristotle, the first principle of life of a living body, and so is therefore a broader concept, encompassing not only subjectivity and cognitive processes but also, in addition, all life-functions, including those of nutrition, growth, and reproduction. To speak of the relation between body (corpus) and soul in Aquinas is not the same thing as to speak of the relationship of mind and body – but Aquinas’ account of the first is critical and foundational for his account of the second.
Aquinas champions – as do the Christian physicalists and materialists whose work will be highlighted in this chapter – this will leave one vulnerable both to error about the relationship of the human to God and to error about the shape of the Christian moral life. Before considering Aquinas’ ethics, then, it is necessary first to trace the contours of the metaphysical psychology from which that ethics is indissociable.

7.2 Four Parameters of Aquinas’ Theological Anthropology

In the following two chapters I will attempt to render an account of Aquinas’ anthropology and moral psychology which is both faithful to Aquinas’ corpus, particularly that of the *Summa theologiae*, and useful to contemporary Christian reflection about psychiatric technology.⁹ Stating things in this way should make clear that I do not intend this primarily as an exercise in historical theology or medieval studies, seeking some sort of unconditioned truth about what Aquinas thought in the scientific and cultural context of his time. As observed in Chapter 6, many of Aquinas’ scientific assumptions and observations are, from the perspective of contemporary science, quite misguided, and the scientific concerns which motivated his conclusions are in many ways different from our own. When Aquinas makes a scientific or normative claim which is not central to his theory and with which I do not concur – for example, his statement in *Summa theologiae* IlaIIae q. 26 a. 10 resp. that strictly speaking, one’s father

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⁹ Following Robert Pasnau’s assessment that the *Summa theologiae* is Aquinas’ most mature work which provides a concise and precise summary of his theology and philosophy, I focus my engagement with Thomas on the *Summa theologiae*. I reference other works by St. Thomas either to provide more context and detail than he provides in the *Summa theologiae*, or to discuss topics (e.g., the characteristics of the eschatological body) which he does not cover in that unfinished work. Robert Pasnau, *Thomas Aquinas on Human Nature: A Philosophical Study of Summa Theologiae* 1a 75-89 (New York: Cambridge University Press, 2002), 3-7.
should be loved more than one’s mother because the father is the “active principle” (*principium per modum agentis*) and one’s mother is a “passive and material principle” (*principium magis per modum patientis et materiae*) – I do not discuss or cite it, and in that sense I freely confess to some selective appropriation of Aquinas’ work. ¹⁰ I am, however, motivated by the conviction that St. Thomas’ metaphysical and psychological theory retains considerable analytic power, opening venerable but forgotten conceptual doors which have been long shut by the self-imposed immanent frame of modern empirical science. I therefore seek an interpretation of Thomas which is faithful to the concerns of his own time (if not a comprehensive reconstruction of his views) and responsive to the concerns of ours.

I will consider in Chapter 8 the question, crucial to any discussion about psychiatric technology, of Thomas’ account of the relationship between the body and the moral life of the person. Prior to that, however, some ground-clearing is necessary, if only because Aquinas’ penchant for complex and nuanced distinctions renders him ever-susceptible to misunderstanding. In this chapter, therefore, I will establish four essential contours of Thomas’ theory of the body-soul unity by describing what it is not (but is potentially mistaken for) and will at the same time defend Thomas against the charges of what I take to be the most influential current proposal within protestant Christian scholarship on the relation of the body to the soul, namely the non-reductive physicalism championed primarily by Nancey Murphy. First, I will argue that although Aquinas holds to a real distinction between body and soul, he is not a Cartesian substance dualist.

¹⁰ This kind of selective rendering, in search of what is true and enduring in Aquinas’ work, is itself consistent with the way that Aquinas treated his philosophical and theological authorities.
Second, Aquinas’ insistence on the non-corporeality of the intellectual faculty of the soul means that he is not a materialist in either its reductive-eliminativist or nonreductive forms. Third, Aquinas opposes any dualistic rendering of body and soul which authorizes escape from, neglect of, or abuse of the body, as if the soul were good and the body were intrinsically evil or corrupt. Fourth, Aquinas, like Aristotle, conceives the human as an intrinsically political animal with specific obligations to others, and he is not an individualist as this is frequently understood in contemporary psychology and political thought.

7.2.1 Aquinas Is Not a Cartesian Substance Dualist

Rene Descartes, in his programmatic *Discourse on the Method of Rightly Conducting the Reason and Seeking Truth in the Sciences* (1637), describes his disillusionment with his Jesuit education in “the study of letters” and states that as soon as he was able to do so, he “resolved no longer to seek any other science than the knowledge of myself, or the great book of the world.”\(^\text{11}\) The latter, however, proved too epistemologically uncertain, and so he undertook “at length . . . to make myself an object of study, and to employ all the powers of my mind in choosing the paths I ought to follow, an undertaking which was accompanied with greater success than it would have

been had I never quitted my country or my books.”\textsuperscript{12} This methodological inward turn led, famously, to his observation that

whilst I thus wished to think that all was false, it was absolutely necessary that I, who thus thought, should be somewhat; and as I observed that this truth, \textit{I think, hence I am}, was so certain and of such evidence, that no ground of doubt, however extravagant, could be alleged by the skeptics capable of shaking it, I concluded that I might, without scruple, accept it as the first principle of the philosophy of which I was in search.\textsuperscript{13}

Because Descartes’ thinking “I” could imagine itself without a body, the body could not be essential to the “I:”

I thence concluded that I was a substance whose whole essence or nature consists only in thinking, and which, that it may exist, has need of no place, nor is dependent on any material things; so that “I,” that is to say, the mind by which I am what I am, is wholly distinct from the body, and is even more easily known than the latter, and is such, that although the latter were not, it would still continue to be all that it is.\textsuperscript{14}

Readers with even a passing familiarity with Aquinas will recognize that St. Thomas’ conception of the human person differs in important and irreconcilable ways from the account that Descartes presents here. Aquinas does make a place in his metaphysical system for substances whose whole essence consists only in thinking (and willing), which have no need of place, and which are wholly distinct from any body. He refers to these beings as \textit{angeli}, angels, and describes them as “purely spiritual creatures,” contrasting them with human beings who are “composite [creatures], corporeal and

\textsuperscript{12} Ibid., 45.
\textsuperscript{13} Ibid., 63.
\textsuperscript{14} Ibid. Descartes’ original French reads as follows: “je connus de là que j'étois une substance dont toute l'essence ou la nature n'est que de penser, et qui pour être n'a besoin daucun lieu ni ne dépend d'aucune chose matérielle; en sorte que ce moi, c'est-à-dire l'âme, par laquelle je suis ce que je suis, est entièrement distincte du corps, et même qu'elle est plus aisée à connoître que lui, et qu'encore qu'il ne fût point, elle ne l'auroit pus d'être tout ce qu'elle est.”
Aquinas goes to considerable length – fifteen questions of the *Summa theologiae* and an equivalent portion of the *Summa contra gentiles* – describing every aspect of angelic being and cognition, directly contrasting the angels at many points to human beings. Angels, we learn, are altogether incorporeal; they do not exist as hylomorphic unities but rather as immaterial forms. Though they can sometimes assume bodies (Aquinas is forced by various scriptural accounts to concede this), they are only accidentally, not naturally, united to these bodies and they do not exercise life-functions in the bodies which they assume. Angels are, to be sure, glorified beings, standing midway between God and corporeal creatures. They have a natural dignity which disposes them to love God naturally, and to attain beatitude with the help of sanctifying grace given to them in the creation. But the life of the angels, for Thomas, is quite different from the lived experience of humans. Angels, after all, can only equivocally be said to be in a place or to move, as they do not exhibit dimensive quantity,

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15 *STh* Ia q. 50 prologue. Recognition of this similarity in description between the Cartesian soul and Aquinas' description of angels has prompted later Thomistically-informed thinkers to dismiss Cartesian dualism as "angelism." Jacques Maritain, for example, after arguing that Cartesian dualism contributed to the movement in subsequent European culture to agnosticism (due to methodological doubt and distrust of theology and metaphysics as epistemological guides) and materialism (due to the Cartesian intellect’s inability to apprehend a supernatural world), argues that Descartes was responsible as well for encouraging individualism: “Intelligence lets itself be deceived by the mirage of a mythical conception of human nature, which assigns to that nature conditions peculiar to the pure spirit, supposes it to be in each one of us as perfect and complete as the angelic nature in the angel, and therefore claims for man, as a gift of nature, full self-sufficiency and absolute independence. Such a conception we may term *anthropocentric individualism,* giving to this word its full metaphysical sense, though it would be more exact to call it *angelism:* a term which is justified by historical as well as doctrinal considerations, for it is in the Cartesian confusion between the human soul and the pure spirit, as in the Leibnitzian confusion between substance, whatever it may be, and the angelic monad, that anthropocentric individualism has its ideal origin and its metaphysical type.” Maritain, *St. Thomas Aquinas* (London: Sheed & Ward, 1946).

16 *STh* Ia q. 50 a. 1 *resp.*

17 *STh* Ia.q. 51. This curious ghost-in-the-machine anticipation of Descartes carries with it all of the intractable questions about body-soul interaction that later plagued Descartes.

18 *STh* Ia q. 50 a. 1 *ad1.*

19 *STh* Ia q. 62 aa. 1-3.
and so all of the experience of inhabiting a body, and therefore a particular place and time, is denied them.\textsuperscript{20} Lacking bodily sense-powers and the cognitive faculties accompanying them, angels do not have the concupiscible and irascible passions which are intrinsic to embodied human life.\textsuperscript{21} Nor do angels have the power in themselves, using the intellectual power alone, to apprehend what particular things are; since they do not have the sense-powers which humans use to identify particulars prior to abstracting their intelligible nature, they must receive information about particulars directly from God.\textsuperscript{22}

Whatever one’s assessment of St. Thomas’ account of the angels – at the very least, he deserves credit for a highly interesting and detailed set of deductions – it is clear that for Aquinas human beings are not angels. The human substance is not the kind of intellectual substance which, if linked to a body, can shed the body and remain the same complete substance in a disembodied state.\textsuperscript{23} The human substance is, rather, a composite unity of body and soul, \textit{corpus} and \textit{anima}. It is true that Aquinas, following Augustine, refers to the human soul as a substance, but Aquinas qualifies this by stating

\begin{footnotesize}
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\item \textsuperscript{20} \textit{STh} Ia. q. 52 a. 1 \textit{resp.}
\item \textsuperscript{21} \textit{STh} Ia q. 59 a. 4 \textit{resp.}
\item \textsuperscript{22} \textit{STh} Ia q. 55 a. 2 \textit{resp}; Ia q. 57 a. 2 \textit{resp}. This was, of course, essentially Descartes’ view of how humans obtain true knowledge of the external world: “For how do we know that the thoughts which occur in dreaming are false rather than those other which we experience when awake, since the former are often not less vivid and distinct than the latter? And though men of the highest genius study this question as long as they please, I do not believe that they will be able to give any reason which can be sufficient to remove this doubt, unless they presuppose the existence of God. For, in the first place, even the principle which I have already taken as a rule, viz., that all the things which we clearly and distinctly conceive are true, is certainly because God is or exists and because he is a Perfect Being, and because all that we possess is derived from him: whence it follows that \textit{our ideas or notions, which to the extent of their clearness and distinctness are real, and proceed from God, must to that extent be true.”} Descartes, \textit{Discourse on Method}, 67, italics added.
\item \textsuperscript{23} The human can indeed intentionally shed the body, of course, through suicide; but he or she does not remain the same complete substance in the disembodied state.
\end{itemize}
\end{footnotesize}
that by this he means that the soul is “something subsistent” (*aliquid subsistens*), capable of subsisting apart from the body,\(^{24}\) not that it is complete in itself with no need of a body. Most precisely, the human soul is a subsistent form.\(^{25}\) The soul is first and foremost for Aquinas the form of the living human body, the first principle of its life, which together with the matter of the human body forms the human substance.\(^{26}\) Even the intellectual principle (*intellectivum principium*) of the soul, which (as we will explore in the next section) Aquinas firmly claims does not depend for its specific operation on any corporeal organ, is still united to the body as its form.\(^{27}\) Aquinas argues this in several ways, of which we will consider only one. Following Aristotle, he holds that when species differ, they derive difference from their respective forms; and since humans differ from other animals specifically in their rationality, the form of the human being must be the intellectual principle (*sed differentia constitutiva hominis est rationale . . . intellectivum ergo principium est forma hominis*).\(^{28}\) Furthermore, just as health is considered a form of the healed body, and knowledge (*scientia*) a form of the knowing mind, so the soul (*anima*, the first principle of life) is the form of the living body. Since the soul, as the principle of life of the body, encompasses all aspects of embodied life, including not just sensation and nourishment but also understanding, the intellectual soul must be the sole form (that is, the substantial form) of the body.\(^{29}\)

\(^{24}\) *STh* Ia q. 75 a. 2 *sed contra*; q. 75 a. 4 ad2.


\(^{26}\) *STh* Ia q. 75 a. 1 *resp.*; Ia q. 75 a. 4; Ia q. 75 a. 5; also see Anthony Kenny, *Aquinas on Mind* (New York: Routledge, 1993), 129-143.

\(^{27}\) *STh* Ia q. 76 a. 1 *resp., ad1.*

\(^{28}\) *STh* Ia q. 76 a. 1 *sed contra*.

\(^{29}\) *STh* Ia q. 76 a. 1 *resp.* Of note, Benedict Ashley writes that the existence of pure created spirits can be rationally proved by specifying that pure, unembodied spirits are the prime movers of independent lines of
Later in the same question Aquinas anticipates, and forcefully rejects, the later Cartesian proposal that the soul, as an immaterial substance, stands outside the body not as its form but as its motor and therefore must be able somehow to move the body, a proposal which has generated unending and intractable speculation about “mental causation.” (Sed hoc est multipliciter vanum: “but this is absurd for many reasons,” Aquinas writes.) It is true, Aquinas writes, that the intellectual principle moves the cognitive apparatus of the body, but not as if the intellect, as a wholly immaterial substance, stands to the body as an external thing applying some sort of external force. Rather, the intellect moves the body through its appetite, the will, and any such movement “presupposes the operation of the intellect.” Aquinas can therefore say that “the reason . . . why Socrates understands is not because he is moved by his intellect, but rather, contrariwise, he is moved by his intellect because he understands.”

This claim is likely to make little prima facie sense to those whose habits of thought are formed by post-Cartesian debates about body and soul, and so requires some retracing of the contours of Aquinas’ metaphysical theory. Aquinas makes a distinction between powers of the soul which are intellectual (which he sometimes refers to as apprehensive) and powers of the soul which are appetitive (which he sometimes refers to as motive). The apprehensive powers cannot properly be said either to demonstrate or to effect movement in themselves; the proper act of the intellect is not movement toward its object, the truth, but rather the apprehension of it, which Aquinas describes not as

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30 ibid; Primo quidem, quia intellectus non movet corpus nisi per appetitum, cuius motus praesupponit operationem intellectus. Non ergo quia movetur Socrates ab intellectu, ideo intelligit, sed potius e converso, quia intelligit, ideo ab intellectu movetur Socrates.
movement toward truth but as rest in it. But the appetitive powers work quite
differently, and Aquinas’ description of this, in which he largely retraces Aristotle, is
very much a ground-up rather than a top-down account. All substances, he states, have a
natural inclination determined by their form, and in inanimate substances this can be
fairly simply described: fire, for example, has a natural inclination to rise and to spread,
and a stone is inclined to fall. Such inclination is not, of course, a cognitive inclination; it
is simply a statement of what a thing “does,” given its nature. But things become more
complex in substances like animals which participate some form of knowledge, because
animals (with sensitive appetites) are receptive to the forms of other things (i.e., a sheep
is receptive to the form of a wolf at the edge of the pasture). When animals (including, of
course, humans) take in the forms of other things, the other things (so to speak) become
internal to them, and so the natural inclination of the animal is related therefore not only
to the animal’s form but also to whatever other forms the animal has (through sense-
perception) internalized. If an internalized form is judged by the “estimative sense” of
the animal to be a good (e.g., a lush pasture for a sheep), the animal will pursue this good.
If an internalized form is judged by the estimative sense to be a danger or an evil (e.g., a
wolf to a sheep), the animal will pursue good by avoiding or confronting this evil. But
none of this, for Aquinas, requires the animal to be somehow externally moved;

31 STh Ia q. 79 a. 8 resp. This account is complicated by Aquinas’ argument that human reason (ratio),
which is proper to humans and is not shared by the angels, differs from intellect in that it involves
movement from particular things understood to intelligible truth, though it is not for that reason to be
considered a separate power. Aquinas does not directly state whether this discursive rationality shares the
intellect’s independence of any corporeal organ, though as he considers them one and the same power he
would presumably hold that discursive rationality is incorporeal. I wish to challenge this, on the ground
that any faculty proper to the human soul and not shared by the angelic soul must, as a logical extension of
Aquinas’ thought, pertain to humans’ corporeality.
32 STh Ia q. 80 a. 1 resp.
everything is, to use a modern metaphor, programmed into the configuration of the animal’s body (a configuration which Aquinas would refer to as the “sensitive soul”).

An animal, by its nature, just *is* the sort of thing that will respond, by approach, avoidance, or confrontation, to other things depending on its valuational stance toward them.

Human beings, for Aquinas, share this configurative capacity with the animals. Specifically, humans share with animals the powers of the soul that maintain nutrition, growth, and reproduction (which, following Aristotle, Aquinas refers to as the vegetative soul) and the powers of the soul manifested by the five senses, perceptual integration of sense-data (*sensus communis*), episodic memory (memorative power, *vis memorativa*), appraisal of threat or reward (estimative power, *vis aestimativa*), and emotion-regulation including fear responses (which Aquinas collectively refers to as the sensitive soul).

Humans, likewise, just *are* the kind of beings whose realization of their form (or, we might say, “becoming what they are”) includes responsiveness, by approach, avoidance, or confrontation, to other perceived sensible things. But human responsiveness is much more complex than that of other animals. Whereas in animals the assignment of value to sensory particulars (i.e., whether the particular is to be pursued or avoided, the worth of things to the animals which Aquinas labels their *intentiones*) is matter of “natural instinct,” humans assign value through a “coalition of ideas”: the valuational capacity which in animals is called the natural estimative (*aestimativa naturalis*) in humans is

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called the cogitativa (cogitativa). Humans, in other words, assign value to things not by responding instinctively to sense-impressions, as the sheep does when faced with a wolf, but by collating and weighing ideas. Although this discursive power is not shared with the rest of the animals and is therefore particularly human, it is still embodied: Aquinas, reflecting prior use, refers to this power as the particular reason (ratio particularis) and notes, without either endorsement or refutation, that medici, “medical men,” assign this power to a “certain particular organ, namely, the middle part of the head” (determinatum organum, scilicet mediam partem capitis).34 Just as the sensitive appetite in an animal responds (by approach, avoidance, or confrontation) to a desired good or perceived threat, so also the sensitive appetite in the human animal will respond by approach, avoidance, or confrontation to a desired good or perceived threat, except that it will be directed not (only) by animal instinct but (also) by the discursive valuational capacity which is particular to human beings. But there is nothing disembodied about any of this: humans are distinguished (so far) by configurational complexity rather than by a power independent of any organ. The body, in this account so far, is indeed moved by reasons, but “reasons” here are not some external spiritual/immaterial force commanding the body to move. They rather name the result of the process by which the embodied human, through a complex sensory-perceptual-cogitative process, assigns salience and value to any percept. The fact that the embodied human acts for reasons is, for Aquinas at this point, no more mysterious than that the sheep instinctively runs from a wolf: both are

34 STh Ia q. 78 a. 4 resp.
using their natural faculties to pursue the course which they judge most consistent with
the preservation and realization of their form – that is, what they naturally are.

Aquinas does not, of course, stop here. The particular reason distinguishes the
human from the other animals, but its deliberations do not provide the terminus for
human practical reasoning. Just as, in humans, the sensitive appetites are moved by the
particular reason, so “this same particular reason is naturally guided and moved
according to the universal reason” (ipsa autem ratio particularis nata est moveri et dirigi
secundum rationem universalem).\textsuperscript{35} It is true that Aquinas claims, for reasons to be more
fully explored in the next section, that the universal reason cannot be dependent for its
operation on any corporeal organ, but Aquinas’ point here is that, because of this natural
openness of the sensitive appetite to the particular reason and of the particular reason to
universal reason, the sensitive appetite can properly said to be guided by universal
reason, not with the latter as an external mover but, rather, as an internal guide to the
assignment of value.\textsuperscript{36}

This excursus should help us to understand Aquinas’ assertion, in the response of
Prima Pars question 76, article 1, that the intellect is not united to the body as its motor,
that appetitive movement presupposes the operation of the intellect, and that “the reason
why Socrates understands is not because he is moved by his intellect, but rather,
contrariwise, he is moved by his intellect because he understands.”\textsuperscript{37} The motor of any
substance with the power to move itself is the natural inclination of the substance to

\textsuperscript{35} STh Ia q. 81 a. 3 resp.
\textsuperscript{36} Ibid.
\textsuperscript{37} STh Ia q. 76 a. 1 resp.
realize its form by pursuing what is perceived to be good. The intellect “moves” the body not by the power of compulsion but, so to speak, by the power of persuasion – what Aquinas, following Aristotle, refers to as a “political and royal” (politicō et regali) power rather than a “despotic” power – showing the appetite its good under the aspect of universal reason.38

As suggested in the account above, not only does the intellect not move the body as a motor, but for Aquinas the incorporeal intellectual principle does not even exhaustively comprise the human activity which we refer to, in subjective experience, as cognition or “thinking.” For Aquinas the human intellect, which apprehends universal truth, is entirely dependent on the senses for knowledge of the world of sensible particulars in which humans find themselves. It is only after the senses internalize external forms and as the “internal sense” of phantasmata generates from this sense-data a cognitive representation of the external sensible (a phantasm) that the active or agent intellect, which pertains to the intellectual part of the soul, can abstract from these phantasms the universal forms of the sensory particulars and inscribe knowledge of these forms on the passive intellect.39 Following Aristotle, Aquinas is quite clear that the intellect can ordinarily only understand intelligible species by turning to the phantasms

38 STh Ia q. 81 a. 3 ad2. An even more parsimonious statement of the relationship of the sensitive appetite to the universal reason is found in the context of Aquinas’ discussion of whether love as a passion exists in God. Arguing that God loves, though not with passion, Aquinas argues that “the cognitive faculty does not move except through the medium of the appetitive: and just as in ourselves the universal reason moves through the medium of the particular reason, as stated in the third book of De anima, so in ourselves the intellectual appetite, or the will as it is called, moves through the medium of the sensitive appetite. Hence, in us the sensitive appetite is the proximate motive-force of our bodies. STh Ia q. 20 a. 1 ad1. [Ad primum ergo dicendum quod vis cognitiva non movet, nisi mediante appetitiva. Et sicut in nobis ratio universalis movet mediante ratione particulari, ut dicitur in III de anima; ita appetitus intellectivus, qui dicitur voluntas, movet in nobis mediante appetitu sensitivo. Unde proximum motivum corporis in nobis est appetitus sensitivus.]

39 STh Ia q. 84 a. 6.
generated by the senses, in part because of the clear observation that cognition is clearly impaired when there is lesion of a corporeal organ or in cases of “frenzy” (*phrenesis*) and “lethargy” (*lethargia*). The implications of this for psychiatric diagnosis and illness are significant, and will be explored more fully in chapters 8 and 9.)

With regard to the Aristotelian model of the tripartite soul, the bottom line of Aquinas’ complicated Aristotelian account of mental function is that much of what we ordinarily experience as “thinking” is attributable by Aquinas to the vegetative and sensitive, rather than the intellectual, faculties of the soul. An example may help to make this clear. As I write this chapter section, I am thinking as hard as I can about how to structure this argument in a way that is faithful to Aquinas and intelligible to readers. In doing so, I find my brow furrowed and the muscles around my eyes and lips tensed slightly, as this seems to help me focus more intently on the computer screen in front of me. Reading over the sentence I just wrote, and not satisfied with it, I delete it and rewrite it; I read it again, and it is satisfactory, at least for now. Unsure of what to write next, I find myself whispering possible constructions of phrases, barely perceptible and hardly conscious even to me, with no clear sense of why I select some and reject others. I recall that Wittgenstein wrote something about what “thinking” feels like – I even remember the look of the text – but I can’t remember where it appears, and so I reach for my copy of the *Investigations* and search, fruitlessly, for it. Attempting to refocus my attention on Aquinas and this argument, I am distracted by the sound of a neighbor’s leaf blower on a crisp autumn afternoon, and aware of a certain haze of focus, slowness of

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40 *STh* Ia q. 84 a. 7 *resp.*
thought, and heaviness in my eyelids that I attribute to the warm room and to the slightly-too-large lunch I just finished. I consider taking a break to make a cup of tea, which surely will help, but decide to press on and furrow my brow slightly more, impatient at my own slow pace. I read the previous few sentences to decide if I have carried on with this introspection far too long . . .

It should be clear that in Aquinas’ taxonomy of the soul’s various functions, the “thinking” required to become proficient in Aquinas’ thought and to write this chapter is psychologically (though not logically) dependent on, and likely inseparable from, the vegetative and sensitive faculties.41 I am only too aware, in thinking about my thinking about Aquinas, that I am a creature both corporeal and intellectual rather than, like the angels, a purely intellectual substance. Thinking about and with Aquinas requires adequate well-functioning of the body’s self-regulatory metabolism, of the external senses which not only provide me access to Aquinas’ texts but also allow me to record linguistic place-markers for my own argument, and of the internal senses which collate and organize my primary sense-experience. Unlike Descartes, I cannot imagine myself without a body because I am all too aware, as are a chorus of other Cartesian critics, that my activity of imagining is an embodied activity.

At this point it should be clear that, at the very least, Aquinas is no proto-Cartesian. The soul relates to the body not as immaterial substance to corporeal substance but, rather, as the body’s form to the body’s matter. The soul is not the res cogitans but the first principle of life of the living body, a principle which non-human

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41 The vegetative and sensitive faculties do not only support the act of “thinking,” of course; they also can hinder it, as we will consider in much more detail in Chapter 8.
animals and other living things share with humans exactly to the extent (and no more)
that they share life with humans. The intellectual principle of the soul does not drive the
body as a motor but, rather, guides the appetite by a “political and royal” rule, showing
the appetite its good under the aspect of universal reason. And much of what we
understand, in our own experience, as cognition or “thinking,” Aquinas would assign to
the function of the vegetative and sensitive faculties of the soul, which are fully
embodied.

7.2.2 Aquinas Is Not a Materialist

Given the above account, it is surprising to see Aquinas dismissed as a proto-Cartesian by two contemporary Protestant writers who reject Cartesianism in favor of
some form of monistic unity of body and soul. Nancey Murphy, for example, writes that
each of the various human faculties “attributed by Thomas Aquinas to the soul” have
been linked by modern neuroscience, in various levels of precision, to the body: the
principle of life to the nervous system, locomotion to cortical and subcortical brain
processes, the *vis memorativa* to the hippocampus and to various neural networks, the
“higher mental faculties” to the brain’s linguistic function, and so on.\(^{42}\) Kevin Corcoran,
while recognizing the arguments of Eleonore Stump and Robert Pasnau that Aquinas is
not a Cartesian dualist, argues that “Aquinas’s view of persons is still a view of
Substance Dualism” due to Aquinas’ argument that the human soul is an immaterial

Both of these critiques, however, miss the point. Murphy, despite acknowledgement that Thomas’ anthropology is not the same as that of Descartes, reads Aquinas through a Cartesian lens, assuming that a psychological faculty “attributed by Thomas Aquinas to the soul” cannot also be, for Aquinas, attributed to the human body; in Murphy’s view, the discovery of a neuroanatomical correlate for, say, vision would count as a refutation of Thomistic dualism. But for Thomas just the reverse is true: Thomas’ theory would in fact predict a neurophysiological basis for most human psychological functions and would therefore not be threatened in the least by modern empirical neuroscience (the sole exception to this is the intellectual faculty, which lies outside the empirical reach of neuroscience and which we will consider momentarily).

Corcoran, on the other hand, convicts Aquinas of guilt-by-dualistic-association without engaging in any actual refutation of his theory. Aquinas, he claims, is not a substance dualist like Descartes and so should better be referred to as a “compound dualist;” but as he does in fact refer to the human soul as a “substance,” he must be a substance dualist and may therefore be dismissed along with Descartes. But this seems unfair to the whole of Aquinas’ work. The idea that perhaps Aquinas uses “substance” in *Summa theologiae* Ia q. 75 a. 2 *sed contra* in order to conform his language to the authority of Augustine, as Pasnau suggests, and would more precisely describe the human soul as a “subsistent form,” is not one which he considers.44

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Corcoran and Murphy are two of a group of contemporary theological thinkers who have recently advocated for a rejection of dualism in favor of some variant of what Murphy refers to as “non-reductive physicalism,” the theory that, in Murphy’s words, “we are our bodies – there is no additional metaphysical element such as a mind or soul or spirit,” but that the phenomenon of top-down causation renders human life irreducible to neurophysiology. These thinkers by no means speak univocally, but they are united in their opposition both to Descartes and to the “classical” Christian theological tradition which prefigured Descartes and which affirms the doctrine of an immaterial soul; and their monistic proposals are currently carrying the day (particularly within protestant contexts) within theological discussions of the body-soul relationship and within the contemporary “science and religion” debate. To this group of thinkers, a monistic view of the human person is compelling for at least three clusters of reasons, each of which deserves consideration. First, as alluded to in Murphy’s quote above, a monistic account of the body-soul relation would seem to be more consistent with the findings of contemporary neuroscience. Second, particularly for Joel Green, a monistic account of the body-soul relation better coheres with biblical evidence regarding the human person. Third, and perhaps most importantly, a monistic account of the body-soul relation helps Christians to avoid gnostic or Platonic denigration of the body and, correlatively, an individualistic soteriology which focuses inordinately on individual spirituality and individual salvation to the exclusion of the sociopolitical and ethical context of the

45 Murphy, *Bodies and Souls, or Spirited Bodies?*, ix. Other theological advocates of some variant of nonreductive physicalism include Warren S. Brown and Joel Green; see especially Joel Green, *Body, Soul, and Human Life: The Nature of Humanity in the Bible* (Grand Rapids, Mich.: Baker Academic, 2008).
present life. Dualistic anthropology, charges Stephen G. Post, is at least contributory to
the phenomena of human slavery, patriarchy, and Christian disparagement of sex. 46
Although the principal targets of this criticism are Plato, Augustine, and Descartes,
Aquinas is (as seen above) often dismissed as a dualist along with the rest.

For good reason, and despite many points of agreement, Aquinas is not a
nonreductive physicalist, or for that matter a physicalist of any sort. Given the intuitive
appeal of nonreductive physicalism to those seeking a theological anthropology which is
responsive to modern neurobiology, however, it is reasonable to expect any argument for
the usefulness of Thomistic anthropology for contemporary Christian appraisal of
psychiatric technology to defend Thomas’ dualism against the charges of modern-day
Christian monists and also to describe why Thomas’ account of body and soul might
actually be preferable to that of non-reductive physicalism. I will proceed with this
defense in three parts, discussing the issues of scientific and biblical credibility in this
section and considering the moral objections in the remaining two sections of this
chapter. Readers will see that the chapter from this point has a dual purpose. As before,
I aim to present for readers several important contours of Aquinas’ view of the human
person. While doing so, however, I will defend Aquinas’ theory against premature
dismissal by those inclined to dismiss any “dualism” in favor of a monistic view of the
person.

I have already argued that Thomas’ account of body and soul, unlike that of
Descartes, presumes a substantial unity of the two under the conditions of bodily life and

Whatever Happened to the Soul?, 195-212.
that therefore contemporary neurobiological discoveries about neural correlates of psychological function offer little challenge to Aristotelian-Thomistic hylomorphism. (One can only imagine, in fact, the excitement with which St. Thomas would have read a contemporary neurobiology textbook.) To the extent that this is true, Thomas’ anthropology is threatened very little by the retrieval within contemporary biblical studies of the unity of the human person (as evidenced, for example, by the pluripotency of the Hebrew *nephesh*) or by the reminder that Pauline eschatology differs substantially from Platonic conceptions of death and afterlife.\(^47\) Aquinas, that is, is not Descartes, and is not as easily dismissed by those who reject Cartesian dualism in favor of a monistic view of the person.

Despite this substantial resonance with modern accounts of body-mind or body-soul monism, however, Aquinas nonetheless consistently holds that “the intellectual principle which we call the mind or the intellect has an operation *per se* apart from the

\(^{47}\) Green, *Body, Soul, and Human Life*, ibid. It should be additionally noted that Aquinas’ treatment of human nature in *STh* Ia qq. 75-89 is only rarely attributed to his biblical exegesis. Prior to Ia q. 89, where Aquinas turns repeatedly to scripture for witness about the function of the separated soul, scripture is directly quoted in the *sed contra* only four times from q. 75 to q. 88 (q. 83 a. 1; q. 86 a. 4; q. 88 a. 1; q. 88 a. 3). In *Ia* q. 75 a. 4, he rejects a rigidly dualistic interpretation of 2 Cor 4:16 (“even though our outer nature is wasting away, our inner nature is being renewed day by day”), arguing that the “inner nature” corresponds to the intellectual faculty of the soul and that the “outer nature” corresponds both to the body and to the sensitive faculty of the soul (*Ia* q. 75 a. 4 ad1). In *Ia* q. 75 a. 6 ad1, discussing the incorruptibility of the human soul, he distinguishes humans from animals not by the presence of a soul but by the origin of the human soul in the breath of God (Gen. 2:7). In *Ia* q. 79 a. 5 *resp*, he reiterates his common invocation of Ps. 4:6 to argue that the human soul derives its intellectual light from God. In *Ia* q. 81 a. 2 *ad2*, discussing whether the irascible and concupiscible appetites obey reason, he interprets Rom 7:23 in a non-dualistic way. In *Ia* q. 83 a. 1, regarding *liberum arbitrium*, he invokes Sir. 15.14 to defend free choice against various other texts which would appear to deny it, without any implication for body-soul dualism. Apart, then, from his use of the parable of the rich man and Lazarus (Lk. 16:19-31) to ground his account of the separated soul, it is reasonable to conclude that Aquinas’ account of body and soul is more informed by his reading of Aristotle than of his scriptural exegesis. For the modern student of scripture, then, the important question is whether Aquinas’ account of body and soul can be rendered compatible with biblical language for ensoulment, particularly *nephesh*, which neither reflect nor are reflected by Greco-Roman philosophical categories. I believe that it can.
body,” an assertion which has no place in nonreductive materialism or any other form of body-soul monism. Why does Aquinas affirm this?

Before answering this question, it is important to remember several caveats from the discussion above. In affirming the incorporeality of the intellect, Aquinas does not hold that the intellect bears no relation to the body: even though the intellectual principle does not depend on the body for its operation, it remains united to the body as its form. He does not mean that the human activity of thinking or cognition is unrelated to the body, which (as discussed above) supplies the active or agent intellect with the phantasms from which the intelligible and universal forms are abstracted. He does not mean that the intellectual faculty will not be impaired under conditions of bodily sickness, fatigue, or injury; he in fact clearly holds that “when the act of the imagination is hindered by a lesion of the corporeal organ, for instance, in case of frenzy; or when the act of the memory is hindered, as in the case of lethargy, we see that a man is hindered from actually understanding things of which he had a previous knowledge.”

So why is it important for Aquinas that the intellectual power be noncorporeal? Initially, his arguments do not seem promising; the reason Aquinas provides in the question of the Summa theologiae in which this question is most directly addressed is not likely to be persuasive to most modern readers. By the means of the intellect, Aquinas holds, humans can have knowledge of “all corporeal natures” (naturas omnium

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48 STh Ia q. 75 a. 2 resp. ipsum igitur intellectuale principium, quod dicitur mens vel intellectus, habet operationem per se, cui non communicat corpus
49 STh Ia q. 76 a. 1.
50 STh Ia q. 84 a. 6 resp.
51 STh Ia q. 84 a. 7 resp. Videmus enim quod, impedito actu virtutis imaginativa per laesionem organi, ut in phreneticis; et similiter impedito actu memorativa virtutis, ut in lethargicis; impeditur homo ab intelligendo in actu etiam ea quorum scientiam praecipit.
Whatever knows certain things cannot have any of them in its nature
“because that which is in it naturally would impede the knowledge of anything else.”
(Aquinas supports this with the observation that a sick man’s tongue, being affected by a
bitter humor, cannot perceive sweet things and so everything tastes bitter to it.)
The intellect, for this reason, can neither be a body nor can understand by means of a bodily
organ.

Aquinas’ invocation of the four-humor theory to illustrate his point, which is
mirrored in his commentary on Aristotle’s De Anima, is unlikely to garner favor with
neurobiologically-minded modern readers. Furthermore, his implication that if the
intellect contained within itself a specific corporeal nature it would be able to cognize
nothing but that nature is not as clear to modern readers as it was for Aquinas. But it is
clear, whether his specific argument succeeds or not, that he is attempting to argue that
the intellect has the capacity to know the natures of all corporeal things – what things are
– in a way which is not limited per se by the body, and that such knowledge is true
because the intellect attains union with that which is known. Humans, in other words,
are uniquely among the animals able to exceed their embodied sensations and perceptions
in order to gain true knowledge of the natures of things – a true knowledge which is

\[\text{52} \quad STh \ \text{Ia q. 75 a. 2 resp. I have changed the 1911 translation from “bodies” to “natures.”}\]
\[\text{53} \quad \text{Ibid. quia illud quod inesset ei naturaliter impediret cognitionem aliorum}\]
\[\text{54} \quad \text{Ibid.}\]
\[\text{55} \quad \text{InDA III.7.131-159.}\]
\[\text{56} \quad \text{Pasnau is among those not convinced; Robert Pasnau, Thomas Aquinas on Human Nature: A}\]
\[\text{Philosophical Study of Summa Theologiae Ia 75-89 (New York: Cambridge University Press, 2002), 48-57.}\]
\[\text{57} \quad \text{This should not imply that Aquinas was beset with skeptical questions about the veracity of sense-}\]
\[\text{knowledge. Unlike Descartes and later thinkers, Aquinas was not overly concerned about the veracity or}\]
\[\text{reliability of sense-knowledge – both the senses and sensibilia are, for Aquinas, gifts of a good God to be}\]
\[\text{received as such – and did not need to posit an incorporeal mind as a refuge of epistemological certainty.}\]
impossible for non-intellectual creatures who are limited to the internal and external senses. How does this happen, and why is important that the intellectual power be incorporeal and immaterial?

The best answer to this question requires attention not only to Aquinas’ statements about intellective cognition but also to his moral psychology. The incorporeality of the intellectual faculty serves both epistemological and moral functions within Aquinas’ thought. This is evident throughout his corpus but is nicely displayed in the second article of the *Prima secundae* in which Aquinas addresses whether acting for an end is unique (proper) to a rational nature. Aquinas answers negatively: all agents, of necessity, act for an end, and so acting for an end is not proper (unique) to the rational nature. There is a crucial difference, however, between how irrational and rational things act for an end. Irrational things are, by necessity, moved to an end by another, through natural inclination (*inclinatio*), and lacking free choice (*liberum arbitrium*) do not direct themselves. Rational beings, however, move themselves to an end; because they have dominion over their actions through their free-will (*liberum arbitrium*), which is the faculty of will and reason . . . . Consequently it is proper to the rational nature to tend to an end, as directing and leading itself to the end: whereas it is proper to the irrational nature to tend to an end, as directed or led by another, whether it apprehend the end, as do irrational animals, or do not apprehend it, as is the case of those things which are altogether void of knowledge.58

58 *STh IaIIae q. 1 a. 2 resp.* Illa ergo quae rationem habent, seipsa movent ad finem, quia habent dominium suorum actuum per liberum arbitrium, quod est facultas voluntatis et rationis. . . Et ideo proprium est naturae rationalis ut tendat in finem quasi se agens vel ducens ad finem, naturae vero irrationalis, quasi ab alio acta vel ducta, sive in finem apprehensum, sicut bruta animalia, sive in finem non apprehensum, sicut ea quae omnino cognitione carent.
But how do rational beings attain knowledge of the end toward which they can then, in free-choice, direct themselves? What kind of knowledge, that is, serves as a condition of possibility for a (free) will?

The object of the will is the end and the good in universal. Consequently there can be no will in those things that lack reason and intellect, since they cannot apprehend the universal; but they have a natural appetite or a sensitive appetite, determinate to some particular good. Now it is clear that particular causes are moved by a universal cause: thus the governor of a city, who intends the common good, moves, by his command, all the particular departments of the city. Consequently all things that lack reason are, of necessity, moved to their particular ends by some rational will which extends to the universal good, namely by the Divine will.\(^{59}\)

In this passage, and others like it, Aquinas hints at why the intellect must be incorporeal, and why the incorporeality of the intellect is indispensable within his moral psychology. As the argument in Ia q. 75 a. 2 resp. holds but does not develop in significant detail, the incorporeality of the intellect is less relevant for the mechanism of cognition (or, correlatively, for any account of “subjectivity” or “consciousness,” neither of which terms have clear uses within Thomas’ psychology) than for the object of cognition. Like other animate beings, humans can apprehend particulars through the external and internal senses of the sensitive soul. But as long as knowledge remains limited to the particular (as long, that is, as the knower is united only to the particular in the act of cognizing), the animal cannot organize its behavior in any “higher-order” way. The sheep can receive,

\(^{59}\) *STh I* *IIae* q. 1 a. 2. ad3. *Ad tertium dicendum quod objectum voluntatis est finis et bonum in universali. Unde non potest esse voluntas in his quae carent ratione et intellectu, cum non possint apprehendere universale, sed est in eis appetitus naturalis vel sensitivus, determinatus ad aliquod bonum particulare. Manifestum autem est quod particulares causae moventur a causa universali, sicut rector civitatis, qui intendit bonum commune, movet suo imperio omnia particularia officia civitatis. Et ideo necesse est quod omnia quae carent ratione, moveantur in fines particulares ab aliqua voluntate rationali, quae se extendit in bonum universale, scilicet a voluntate divina.*
through the sense of sight, the form of the wolf\textsuperscript{60} and, due to its natural inclination, can run from it; but for the sheep this is determined in its nature. The sheep is not free to run, or not to run, or to devise a counter-strategy for fighting the wolf population; the sheep just \textit{is} the kind of animal which is naturally configured to run from wolves. Because its behavior is so determined, it cannot be said to be acting with reason or with will and must therefore be moved by a will external to it (God).

Humans, though, are not sheep. The human, created in God’s image, is not simply a passively moved divine instrument; rather, the human is “the \textit{principium} of his actions, as having free-will and control of his actions.”\textsuperscript{61} This means, first, that the human can cognize not only \textit{this} wolf but can cognize “wolfness,” the universal form through which particular wolves are what they are. This alone gives humans infinitely more freedom and flexibility in responding to wolves. (Instead of running, for example, the human can learn about wolf habits, trap them, and move them to a different habitat.)

One might object that this proves only that humans have the capacity to name groups of particulars, not to apprehend universals in any metaphysically meaningful way. (“Wolf,” that is, could be simply a convention for naming common particulars, nothing more.) Indeed, Aquinas is clear that “universals, inasmuch as they are universal, exist only in the soul;” it is the natures to which the universal apply that exist in the world, though always individuated into material particulars.\textsuperscript{62} But what about truths of logic which do not derive immediately from sensible particulars: say, the law of

\textsuperscript{60}\textit{STh} Ia q. 78 a. 3 \textit{resp; InDA} II.24.45-59.

\textsuperscript{61}\textit{STh IaIIae prooemium}. The full clause is as follows: \textit{restat ut consideremus de eius imagine, idest de homine, secundum quod et ipse est suorum operum principium, quasi liberum arbitrium habens et suorum operum potestatem.}

\textsuperscript{62}\textit{InDA} II.12.139-151.
noncontradiction, or the laws of geometry? Are they also simply conventions of naming which cannot be said to exist per se, or do they have real existence apart from the cognizing brain? Aquinas would here respond that the laws of geometry are not simply conventions but are principles “known by the natural light of the intelligence.” But these “first indemonstrable principles” (principia prima indemonstrabilia) cannot be known through sense-knowledge, which focuses only on particulars; they must be known through the intellect which, like these universal first principles, is immaterial. They are not simply conventions of naming or tools for getting along in the world; they exist within the divine ratio. The immateriality of the intellect, then, names for Aquinas the truth that embodied, temporally bound, contingent humans have been given by God the ability both to know and to order our lives according to the ratio of God.

This presents an important counterpoint for Christian materialists who seek an adequate theological anthropology without an incorporeal soul: if Christian materialists wish to discount the immateriality of the intellect, they need to account for how embodied humans can know and order themselves according to the things of God without falling into agnosticism. When they do this they often run into difficult terrain. Nancey Murphy, for example, does not believe that the soul’s existence or incorporeality are necessary for knowledge of God or of moral agency, but her account of this exemplifies the difficulties of this approach. Murphy argues that “God is not only beyond the cosmos (transcendent) but also immanent in all of creation, including the physical,” and asks why

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63 STh Ia q. 1 a. 2 resp.
64 STh Ia q. 79 a. 9 resp. Aquinas agrees with Aristotle, against what he takes to be the doctrine of Plato, that universal forms do not exist in reality as separated substances; they do, however, exist in God as divine ideas, such that “the nature proper to each thing consists in some degree of participation in the divine perfection” STh Ia q. 14 a. 6 resp; see also STh Ia q. 85 a. 3 ad4.
God could not “[make] us aware of the divine presence, [speak] to us, [heal] our emotions, by acting on the neural and other bodily processes that give rise to consciousness?”65 This begs the question, though, of how God acts on these neuronal and other bodily processes, and Murphy proposes that this divine action occurs at the indeterminate quantum level:

If God is immanent in and acting in all creatures, then necessarily God is acting at the quantum level. Emphasis on this fact has the advantage of sidestepping the problem of interventionism: the laws of quantum mechanics are only statistical and therefore not subject to violation. If, as most interpreters conclude, events at this level are genuinely indeterminate, then there need be no competition between divine action and physical causation. It is possible from a theistic perspective to interpret current physics as saying that the natural world is intrinsically incomplete and open to divine action at its most basic level.66

One problem with this account, Murphy states, is that many think that divine activity at the quantum level would “have too few meaningful effects at the macroscopic level.”67 Murphy therefore concedes that

if God’s action is located at the quantum level then the scope of God’s action would indeed be limited . . . However, this is not a defect in a theory of divine action but rather an asset because it helps to explain why a benevolent God does not act more frequently and dramatically to remedy the sufferings of humans and other sentient creatures. Perhaps it will turn out that this attempt to integrate divine action and natural causation will explain the fact that the vast majority of Christians expect and pray for some sorts of divine assistance (healing, good weather, and especially our personal relationships with God) but not others (filling teeth, restoring lost limbs).68

From a Thomistic perspective, Murphy’s account of the divine-human encounter is flawed due to insufficient distinction of creator from creation, matter from form, and

65 Murphy, Bodies and Souls, or Spirited Bodies?, 124.
66 Ibid., 131.
67 Ibid.
68 Ibid., 132.
efficient causation from formal and final causation. Of course God works in and through human bodies, a Thomist would hold: Aquinas, after all, states repeatedly that the sacraments are gifts which a gracious God offers to meet embodied humans where they are. Of course our religious experience “can be understood as mediated by ordinary cognitive and affective capacities;” it is the operation of the senses, for Aquinas, which provides the content for intellectual reflection. But for Aquinas God is not, as Murphy’s account here would imply, a benevolent strategist seeking points of indeterminacy in the natural order in which to intervene in that order. A God of this sort, limited by quantum physics, would still be part of the universe, a thing influencing other things. But God, for Aquinas, is not a thing; God is rather the sustaining cause of all things. Because God’s essence is to be, all things derive their being from God and are insofar as they participate in God’s being. All activity and configuration of matter, for Aquinas, originates in God, either immediately or through secondary causes; because Aquinas refers to a substance’s act and configuration as its form, we may then say that God moves the matter of a substance by enacting it, or informing it. This act or form, considered in itself, is immaterial, since it describes not matter per se but rather matter’s configuration. That this distinction between (configured/formed) matter and its (immaterial) configuration/form can only be spoken of by means of signs provides Aquinas with a simple and yet elegant way to speak of God’s activity in the world: God moves matter by enacting or informing it, in such a way that this immaterial act/form can be said to

69 STh IIIa. q. 61 a. 1 resp.
70 Murphy, 122.
71 STh Ia q. 44 a. 1 resp.
72 STh Ia q. 105 a. 1 resp., a. 2 resp.
participate in God’s immaterial ratio. The “laws of nature” participate in this ratio, as secondary causes, though God, as first cause, is not subject to this secondary order and so can work outside of it. Furthermore, this distinction between matter and form gives Aquinas a powerful way to describe the participation of embodied humans in the life of God: humans are configured in such a way that they are capable of participating not only in God’s being (as with all other things in creation) but also, as God’s image-bearers, of participating in God’s cognition of material things and God’s ordering of the world. But none of this participatory language is available to the Christian materialist.

7.2.3 Aquinas Does Not Neglect the Importance or Dignity of the Body

The third contour of Aquinas’ anthropology, important for understanding his account of human actions, is the emphasis he places on the importance of the body in the moral and spiritual life of the person and the importance of proper care for the body. This must be stated because “dualism” is often associated with neglect or abuse of the body. Murphy provides one variant of this criticism when she makes clear that her objections to Christian doctrines of incorporeal soul are theological and ethical as well as scientific:

What might theology be like today, and how might Christian history have gone differently, if a physicalist sort of anthropology had predominated rather than dualism? It seems clear that much of the Christian spiritual tradition would be different. There would be no notion of care of the soul as the point of Christian disciplines – certainly no concept of depriving the body in order that the soul might flourish. As some feminist thinkers have been saying for some time:

73 STh Ia q. 105 a. 6 resp., a. 6 ad1.
dualist anthropology all too easily leads to disparagement of the body and all that goes along with being embodied.74

After disclosing her anabaptist commitments, she suggests that “adoption of a dualist anthropology in the early centuries of the church was largely responsible for changing Christians’ conception of what Christianity is basically all about,” and that “original Christianity is better understood in socio-political terms than in terms of what is currently thought of as religious or metaphysical.”75

There are two important claims here: first, that a dualistic anthropology contributes to the neglect or, worse, the abuse of the body; and second, that a dualistic anthropology promotes a theologically-reinforced individualism which ignores the sociopolitical dimension both of the Christian life and of human life in general. Whether or not these are fair criticisms of some forms of Christian dualism, I believe that both are false when applied to Thomas’ anthropology. I will address the first of these concerns (pertaining to the body) in this section and address the second (pertaining to individualism) in the next.

St. Thomas’ initial treatment of the body in the Treatise on Happiness of the Summa theologiae (IaIIae qq. 1-5) seems to reinforce Murphy’s concern. It would seem, Aquinas writes, that human happiness consists in bodily goods; after all, Sirach holds that “there is no riches above the riches of the health of the body” (Sir. 30:16) and the health of the body is requisite for the goods of being and living. But Aquinas argues, on the contrary, that this cannot be because humans surpass all other animals with regard to

74 Murphy, Bodies and Souls, or Spirited Bodies?, 27.
75 Ibid., 28.
happiness (*beatitudo*) even though many animals have greater bodily goods (*bona corporis*), in at least certain traits and respects, than do humans. He furthermore cites two reasons why human beatitude cannot consist in the goods of the body. First, a thing which is ordered to another as its final end cannot at the same time have as its last end the preservation of its being. A captain of a ship, for example, cares ultimately not about the preservation of his ship but about reaching the ship’s intended destination. Second, the body is dependent on the soul for its being, not *vice versa*, and the body is *for* the soul, not vice-versa:

For man’s being consists in soul and body; and though the being of the body depends on the soul, yet the being of the human soul depends not on the body, as shown above; and the very body is for the soul, as matter for its form, and the instruments for the man that puts them into motion, that by their means he may do his work. Wherefore all goods of the body are ordained to the goods of the soul, as to their end. Consequently happiness, which is man’s last end, cannot consist in goods of the body.  

Such a statement might be interpreted as endorsing neglect or abuse of the body, but this would miss the point of the above article and would be a terrible misreading of Aquinas’ overall treatment of the body in the *Summa theologiae* and other works. That Aquinas did not view the health or “goods” of the body as the *last* end of human life in no way implies that human beatitude is unrelated to the goods of the body. Elaborating on this theme later in the *Treatise on Happiness*, Aquinas argues that the body is not, strictly speaking, necessary for human beatitude primarily because “the dead who die in

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76 *STh IaIIae q. 2 a. 5. resp.* Esse enim hominis consistit in anima et corpore, et quamvis esse corporis dependeat ab anima, esse tamen humanae animae non dependet a corpore, ut supra ostensum est; ipsumque corpus est propter animam, sicut materia propter formam, et instrumenta propter motorem, ut per ea suas actiones exerceat. Unde omnia bona corporis ordinantur ad bona animae, sicut ad finem. Unde impossibile est quod in bonis corporis beatitudo consistat, quae est ultimus hominis finis.
the Lord” are attested in scripture to be blessed (Rev. 14:13). But he qualifies this in two important ways. First, in this life the body is in fact necessary for human happiness, since both the speculative and practical intellect depend, as discussed above, on the phantasms produced by the embodied sensitive faculty of the soul. “Consequently that happiness which can be had in this life depends, in a way, on the body.” Second, because the human is essentially a body-soul unity, the proper operation of the soul entails the proper operation and well-functioning of the body. He then elaborates even further in the next article, in which he considers whether perfection of the body is necessary for beatitude. It would seem not, in part because he has already argued that beatitude does not consist in bodily goods. But in the response Aquinas emphatically rejects the assertion that for the soul to be happy it must be severed from everything corporeal, calling this “unreasonable” (inconveniens). Rather, the perfection of the body is part of the perfection of the soul in this life, and therefore “if we speak of that happiness which man can acquire in this life, it is evident that a well-disposed body is of necessity required for it.” This works bidirectionally. On one hand, an adequately well-functioning body is necessary (in this life) to free the soul to contemplate higher things. On the other, the beatitude of the soul results in a kind of “overflow”

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77 StTh I-IIae q. 4 a. 5 sed contra, resp.
78 StTh I-IIae q. 4 a. 5 resp. Et sic beatitudo quae in hac vita haberi potest, dependet quodammodo ex corpore.
79 Ibid. The passions, to be explored in more detail in the next chapter, are an important psychophysiological nexus in which this ordering of the body takes place.
80 StTh I-IIae q. 4 a. 6 obj. 1.
81 StTh I-IIae q. 4 a. 6 resp. Si loquamur de beatiudine hominis qualis in hac vita potest haberi, manifestum est quod ad eam ex necessitate requiritur bona dispositio corporis.
(redundantia) to the body, allowing it to attain its perfection.\footnote{Ibid.} We have, here, an outline of a kind of virtuous “feed-forward” cycle of health, in which the well-functioning of the body enables the well-functioning of the soul (including the well-functioning of the incorporeal intellectual and volitional powers), which then further reinforces and contributes to the well-functioning of the body, which further aids the well-functioning of the soul, and so on. (We will deal in more detail in the next chapter with the particular situations, such as injury or disease, which complicate this account.)

There is therefore no place in Aquinas’ moral psychology or ascetical theology for the denigration, denial, or neglect of the body. We will consider this issue more deeply in the next chapter, but for now, several different examples (among many possible others) from the \textit{Summa theologiae} should suffice to support this claim.

First, In \textit{Summa theologiae} IaIIae qq. 37-38, to be considered later in more detail, Aquinas affirms that pain (\textit{dolor}) and sorrow (\textit{tristitia}) can make it nearly impossible for the soul to learn or to attend to higher things, and that sorrow can burden the soul, hinder action, and harm the body.\footnote{STh IaIIae q. 37.} Among appropriate therapies for sorrow, he writes, are \textit{not only} intellectual activities like the contemplation of truth\footnote{STh IaIIae q. 38 a. 4.} \textit{but also} common-sense bodily activities like crying, pursuing virtuous and pleasurable things, sleeping, bathing, and entering the company of sympathetic friends.\footnote{STh IaIIae q. 38 articles 1, 2, 3, 5.; Stephen Loughlin, “Tristitia et Dolor: Does Aquinas Have a Robust Understanding of Depression?” \textit{Nova et V"et"era} 3 (2005): 761-784.}
Second, in *Summa theologiae* IIaIIae q. 168, after clarifying that virtue can pertain to bodily movements as well as to inward dispositions of the soul,\(^{86}\) Thomas affirms the importance of play and rest for the life of both body and soul:

> Just as man needs bodily rest for the body’s refreshment, because he cannot always be at work, since his power is finite and equal to a certain fixed amount of labor, so too is it with his soul, whose power is also finite and equal to a fixed amount of work. Consequently when he goes beyond his measure in a certain work, he is oppressed and becomes weary, and all the more since when the soul works, the body is at work likewise, in so far as the intellective soul employs forces that operate through bodily organs.\(^{87}\)

Because the body needs rest, Aquinas holds, there is a virtue in play and relaxation. Although excess or inordinate play can be sinful,\(^{88}\) Aquinas goes so far as to hold, with Aristotle, that the *lack* of mirth is a vice insofar as, lacking playfulness and mirth, a person can be unable to rejoice in the pleasures of others and can become burdensome and boorish.\(^{89}\)

Third, although Aquinas wholeheartedly affirmed ascetical and penitential practices which assisted with the proper ordering of the body to its final (extrinsic) end, he emphasized moderation and did not endorse practices which damaged or neglected the body. He holds fasting, for example, clearly to be a virtuous practice because (quoting Augustine) “fasting cleanses the soul, raises the mind, subjects one’s flesh to the spirit, renders the heart contrite and humble, scatters the clouds of concupiscence, quenches the

\(^{86}\) *STh* IIaIIae q. 168 a. 1.

\(^{87}\) *STh* IIaIIae q. 168 a. 2 *resp*. Respondeo dicendum quod, sicut homo indiget corporali quiete ad corporis refocillationem, quod non potest continae laborare, propter hoc quod habet finitam virtutem, quae determinatis laboribus proportionatur; ita etiam est ex parte animae, cuuius etiam est virtus finita ad determinatas operationes proportionata, et ideo, quando ultra modum suum in aliquas operationes se extendit, laborat, et ex hoc fatigatur, præsertim quia in operationibus animae simul etiam laborat corpus, inquantum scilicet anima, etiam intellectiva, utitur viribus per organa corporea operantibus.

\(^{88}\) *STh* IIaIIae q. 168 a. 3.

\(^{89}\) *STh* IIaIIae q. 168 a. 4 *resp.*
fire of lust, [and] kindles the true light of chastity."\textsuperscript{90} And yet in the same article Aquinas quotes Jerome in a scathing critique of those who would fast in a way which compromises the well-being of the body:

> Reason does not retrench so much from one’s food as to refuse nature its necessary support: thus Jerome says: \textit{It matters not whether thou art a long or a short time in destroying thyself, since to afflict the body immoderately, whether by excessive lack of nourishment, or by eating or sleeping too little, is to offer a sacrifice of stolen goods.} In like manner right reason does not retrench so much from a man’s food as to render him incapable of fulfilling his duty. Hence Jerome says: \textit{Rational man forfeits his dignity, if he sets fasting before chastity, or night-watchings before the well-being of his senses.}\textsuperscript{91}

There is no virtue for Aquinas, therefore, in ascetical practices which compromise the body’s health and ability to function.

\subsection*{7.2.4 Aquinas Is Not An Individualist}

The final contour of Aquinas thought, which is also a response to a common critique of contemporary Christian materialists, is that Aquinas’ theological anthropology is deeply aware of and engaged with the social and political constitution of human life. Murphy, in one variant of this critique, charges that description of the soul as incorporeal deflects Christian attention away from the sociopolitical character of Christian life and to the good works in the material world to which Christians are called. She begins by

\textsuperscript{90} \textit{Th} I\textit{IaIIae q. 147 a. 1 resp.} Ieiumium purgat mentem, sublevat sensum, carnem spiritui subiicit, cor facit contritum et humiliatum, concupiscentiae nebulas dispregit, libidinum ardores extinguit, castitatis vero lumen accendit.

\textsuperscript{91} \textit{Th} I\textit{IaIIae q. 147 a. 1 ad2.} Non tamen ratio recta tantum de cibo subtrahit ut natura conservari non possit, quia, ut Hieronymus dicit, \textit{non differt utrum magno vel parvo tempore te interimas; et quod de rapina holocaustum offert qui vel ciborum nimia egestate, vel manducandi vel somni penuria, immoderate corpus affligit.} Similiter etiam ratio recta non tantum de cibo subtrahit ut homo reddatur impotens ad debita opera peragenda, unde dicit Hieronymus quod \textit{rationalis homo dignitatem amittit qui ieiuniun caritati, vel vigilia sensus integritati praefert.}
comparing the “forms of life” of her own church, the anabaptist Church of the Brethren, and its motto “continuing the work of Jesus, peacefully, simply, together,” with the prevalent understanding of her students at a prominent American evangelical seminary that “Christianity is basically about something else – having one’s sins forgiven and eternal life.” She blames this latter attitude on Augustine’s focus on interiority, which she holds to be different from but closely related to Augustine’s dualism of body and soul. The ascetical tradition which locates the “inward” as the locus of spirituality is, for Murphy, a mistake, and she briefly cites Nicholas Lash, Fergus Kerr, George Lindbeck, Alasdair MacIntyre, and especially Episcopal theologian Owen Thomas as contemporary thinkers who have challenged the inward-outward distinction, mostly on Wittgensteinian grounds. She endorses Owen Thomas’ view that the relationship between inner and outer in Christian spirituality should be “reformulated” by a renewed emphasis in Christian formation on the significance of the body, the material, social, economic, political, and historical world rather than an exclusive focus on the soul or interior life. This emphasis is obviously founded on the centrality in Christian faith of the themes of creation, incarnation, history, and consummation, including the resurrection of the body.

The body, Murphy insists, should not be used as merely “a foil for the progress of the soul.”

Murphy is not alone in linking dualism to a neglect of the sociopolitical character of Christian life. Joel Green, focusing on the holistic descriptions of salvation in the New Testament, holds that “a Christian conception of human transformation does not allow

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92 Murphy, *Bodies and Souls, or Spirited Bodies?*, 28.
93 Ibid., 34-35.
94 Ibid., 35.
the categorization of either the person or his or her salvation into ‘parts,’ as though inner and outer life could be separated,” and that “only an erroneous body-soul dualism could allow – indeed, require – ‘ministry’ to become segregated by its relative concern for ‘spiritual’ versus ‘material’ matters.”

Stephen Post, already cited above, charges that dualism, in addition to contributing to the legitimization of slavery and denial of the “pleasure principle,” contributed both to the prioritization of celibacy over marriage and of gender inequality within marriage – both of which, Post charges, greatly exaggerate the witness of the New Testament writings.

These critics are not wrong in their concern for forms of Christian practice which have, at various times, devalued the goodness of the body, tended toward gnostic spiritual practices, discouraged Christian participation in the polis, and encouraged unjust relationships of status and power. But to blame any non-physicalist “dualism” for this is to paint with much too broad a brush. Post’s body-denying dualists have much more in common with the Albigensians/Cathars whom St. Dominic and St. Thomas so firmly opposed than with Aquinas himself. For Aquinas, in fact, human life is not only inseparable from the body (as discussed in the last section) but also inseparable from the sociopolitical community.

Some contemporary Thomistic thought emphasizes the singularity of the person in St. Thomas’ thought in a way which could be (mis-)interpreted as a defense of individualism. Brennan, for example, highlights that for both Aristotle and Aquinas

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95 Green, Body, Soul, and Human Life, 69-70.
substance signifies something that has existence rightfully in itself, and not in another.  
This is then divided into first substance, which is neither said to inhere in any subject nor 
predicated of a subject (an individually subsistent nature, always singular) and second 
substance, which does not inhere in a subject yet is predicated of a subject (always a 
universal). “Second substance, as a universal, can be said of something else. First 
substance, as a singular, cannot be said of something else.”  
As a first substance, an 
individual substance of a rational nature, the human person is for Aquinas an individuum, 
a substance does not inhere in any subject and which is itself the foundation, the 
suppositum, of accidents.  

In addition, in a move which seems to reinforce the concerns of the Christian 
physicalists, Aquinas employs the doctrine of the incorporeal intellect to distinguish 
clearly between the active life (vita activa) and the contemplative life (vita 
contemplativa). The active life is the moral life, the life of engagement in the polis; the 
contemplative life is the life spent in contemplation of divine truth.  
Following Aristotle 
(Nicomachean Ethics X. 7,8) and various scriptural texts, Aquinas provides a long list of 
reasons why the contemplative life is “more excellent” (potior) than the active life, 
including that the contemplative life is associated with greater delight (delectatio), that 
the contemplative person is more self-sufficient (magis sibi sufficiens), and that the

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96 Robert Brennan, Thomistic Psychology: A Philosophical Analysis of the Nature of Man (New York: MacMillan, 1941), 32.
97 Ibid.
98 Ibid., 280-289.
99 STh IIaIIae q. 179 a. 1 resp.
contemplative life pertains to the intellect, which is most proper to humans rather than the “brutes” (*brutis*).  

In no way, however, is Aquinas’ defense of the *vita contemplativa* intended as a disparagement of the *vita activa*. This is not only evident because, prior to this discussion of the *vita contemplativa* toward the conclusion of the *Secunda secundae*, he has devoted hundreds of questions to a densely detailed analysis of the Christian *vita activa*. It is also because the active life turns out, for Aquinas, to be prior to and complementary to the contemplative life. To those who would charge that the active life is a hindrance to clear vision of divine truth, Aquinas replies that in fact habituation in moral virtue in the *vita activa* is necessary for the passions of the soul to be sufficiently “quieted and directed,” “and from this point of view the active life is a help to the contemplative.” The active life, the life of sociopolitical engagement and moral activity, turns out to be the soil out of which the contemplation of divine truth in this life, if it arises at all, must spring. The person who has not schooled his passions through habituation in the moral virtues will find attempts at contemplation unsustainable.  

It is also important to note that Aquinas’ human *individuum*, despite its nonadherence in any subject, nonetheless lives a participatory life. As first substance, it participates in second substance of (universal) human nature; although matter is its principle of individuation, human nature stands as its formal cause. Furthermore,
although it exists as *individuum*, it does not *necessarily* exist; its existence is gifted to it by participation in the *actus purus*, God, whose essence alone includes existence.\(^{103}\)

Human life, then, is always for Aquinas to be received as gift. It is, furthermore, a specific sort of gift, as its first cause (God) is also its final cause, insofar as “all things desire God as their end, when they desire some good thing.”\(^{104}\) This metaphysical truth, for which Aquinas argues without recourse to *sacra doctrina*, is reinforced by and elaborated within his discussion of the theological virtue of charity. It turns out, for Aquinas, that humans participate not only in God’s existence but also, through grace, in God’s love/charity (*caritas*), which enlivens the soul just as the soul enlivens the body.\(^{105}\) Charity is, for Aquinas, the gracious love of God which, superadded to the natural power of the human will, enables humans to love God in return with “ease and pleasure.”\(^{106}\) Charity, the most excellent of the virtues,\(^{107}\) is also the form of them all, directing all of the other virtues to their last end, God.\(^{108}\)

The grace-enabled love of God by which God enables humans to love God, however, does not include only God as its object. It also includes, by extension, those whom God loves, since to love God is to love God’s good things, and to love the goodness in all things.\(^{109}\) This includes, in particular, other human beings, who are co-participants in the divine *ratio*, even those who are enemies (Aquinas writes that just as one might love the hostile children of a friend because one loves their parent, one loves

\(^{103}\) *STh* Ia q. 44 a. 1 *resp.*

\(^{104}\) *STh* Ia q. 44 a. 4 *ad3*. . . . *omnia appetunt Deum ut finem, appetendo quodcumque bonum . . .*

\(^{105}\) *STh* IIaIIae q. 23 a. 1 *ad1, ad2.*

\(^{106}\) *STh* IIaIIae q. 23 a. 2 *resp.*

\(^{107}\) *STh* IIaIIae q. 23 a. 6.

\(^{108}\) *STh* IIaIIae q. 23 a. 8 *resp.*

\(^{109}\) *STh* IIaIIae q. 25 a. 1 *resp.*
even one’s enemies for God’s sake).\textsuperscript{110} To love God, for Aquinas, is not to be directed
toward one’s own good alone but is rather to be other-directed; it is notable in this regard
that justice, which stands alone among the moral virtues in its irreducible sociality, is
considered by Aquinas to be the greatest of the moral virtues, in part because “[whereas]
the other [moral] virtues are commendable in respect of the sole good of the virtuous
person himself, . . . justice is praiseworthy in respect of the virtuous person being well
disposed towards another, so that justice is somewhat the good of another person.”\textsuperscript{111}
Indeed, for Aquinas the love of others is inseparable from the love of self: humans are to
love themselves as good things of God just as they love the other under the same aspect,
and the \textit{caritas}-informed love of self provides a sustainable basis whereby the self is able
to establish friendship with others.\textsuperscript{112}

The grace-enabled participation of the human in God’s charity is not only social
but also embodied. For Aquinas our bodies, which are limited to the particular, cannot
properly be said to love and to know God – only the incorporeal intellect, freed from the
constraints of particularity, can do that – but “by the works which we do through the
body, we are able to attain to the perfect knowledge of God.” This doxological joy then
“overflows” (\textit{redundat}) to the body, which participates in the soul’s happiness and, on
that account, must be loved with the love of charity.\textsuperscript{113}

\begin{flushright}
\textsuperscript{110} \textit{STh} IIaIIae q. 25 a. 8 \textit{resp.}
\textsuperscript{111} \textit{STh} IIaIIae 1. 58 a. 12 \textit{resp.} Thomas’ Latin, the translation of which I have altered above, is as follows:
\textit{Nam aliae virtutes laudantur solum secundum bonum ipsius virtuosi. Iustitia autem laudatur secundum quod virtuosus ad alium bene se habet, et sic iustitia quodammodo est bonum alterius . . .}
\textsuperscript{112} \textit{STh} IIaIIae q. 25 a. 4 \textit{resp.}
\textsuperscript{113} \textit{STh} IIaIIae q. 25 a. 5 \textit{resp.} Ad secundum dicendum quod corpus nostrum quamvis Deo frui non possit
cognoscedo et amando ipsum, tamen per opera quae per corpus agimus ad perfectam Dei fruitionem
possimus venire. Unde et ex fruitione animae redundat quaedam beatitudo ad corpus, scilicet sanitatis et
\end{flushright}
This embodied, social participation in God’s love turns out to be embodied, social participation in God’s very life. In the sacrament of baptism, among other effects, humans are incorporated (incorporeatur) into Christ, and the visible sacrament of the baptismal waters ensures, so to speak, a corporeal incorporation (or, perhaps, a bodily in-bodying), in which the body-soul unity is directed in its whole toward the divine life. Incorporated corporeally into Christ, the embodied soul participates in God’s triune life, participating in the Word which Aquinas, quoting Augustine, speaks of as “knowledge with love” (notitia . . . cum amore), the “intellectual illumination which breaks forth into the affectation of love.” This is, of course, precisely the love between the Father and the Son who is the Holy Spirit, to which the soul is assimilated by the infused virtue of charity.

7.3 Conclusion: The Eschatological Body

In this chapter I have traced four broad contours of Aquinas’ theological anthropology, both through direct exposition and through defense of Aquinas against modern theological critics of “dualism.” First, Aquinas is not a proto-Cartesian substance dualist; Descartes’ model of soul and body much more closely resembles Aquinas’ description of angels which inhabit human bodies than Aquinas’ description of the human person, who is properly understood as a body-soul unity. Second, however, Aquinas is

incorruptionis vigor; ut Augustinus dicit, in epistola ad Diosc. Et ideo, quia corpus aliquo modo est particeps beatitudinis, potest dilectione caritatis amari.

114 STh IIIa q. 69 a. 5 resp., ad 1. Aquinas says that whereas adults who desire baptism are incorporated mentally into Christ, those who are baptized are incorporated corporally, “incorporantur . . . corporaliter.”

115 STh Ia q. 43 a. 5 ad2.

116 STh Ia q. 37 a. 2.

117 STh Ia q. 43 a. 5 ad2.
not a monist or materialist because he consistently asserts the real distinction of body and soul (the soul is the form of the body, the first principle of its life) and the non-corporeality of the soul’s intellectual faculty. This non-corporeality of the intellect, I argued, is less relevant for the mechanism of cognition for Aquinas, for whom “thinking” in this life is still dependent in many ways on the senses and the phantasms, than for the universal object of cognition. Third and fourth, however, Aquinas successfully avoids certain pitfalls of “dualism” attributed to it by contemporary critics. His moral theology, while asserting that beatitude pertains most properly to the life of the soul rather than to the body, nonetheless condemns destructive ascetic practices and places great emphasis on the importance of proper care for the body, which must be nourished and trained in virtue in order to allow the (properly non-corporeal) intellect and will to exercise their proper functions. Furthermore, despite asserting that the human person, as first substance, is individuum, and asserting that the vita contemplativa is a more excellent form of life than the vita activa, Aquinas places great emphasis on the social and political nature of human life, even asserting that the habituation of the soul in charity necessarily includes love not only of God but, in God, of others including one’s enemies, of one’s self, and of one’s body. The life of the human, for Aquinas, is a participatory life, as the embodied soul participates not only in God’s being but also, through supernatural grace, in God’s eternal trinitarian love-act.

It should come as no surprise, given Aquinas’ respect for and concern for the body, to learn that for him, as for many previous readers of the New Testament, human life in beatitude is an embodied life. Aquinas did not live to write a sustained treatment
of eschatology in the *Summa theologiae*, but his discussion of the life of beatitude in *Summa contra gentiles* IV.79-97 strongly champions not only the resurrection of the body but, more specifically, the resurrection of *this* body, composed of the “flesh and bones which now compose it.”\(^{118}\) This does not mean, of course, that things are not quite different after the resurrection than before. Although sexual differentiation will remain – sexual organs, after all, are part of a body’s natural goodness\(^{119}\) – each body will rise “in the age of Christ, which is that of youth, by reason of the perfection of nature which is found in that age alone.”\(^{120}\) Also, notably, the resurrected body will have no need of dimensional increase or of propagation of the human species, and so (one is tempted to say wistfully) there will be no eating of food or sexual activity in the resurrected body.\(^{121}\)

The principal difference between human life between birth and death and human life after resurrection is not that the first life is embodied and the second is disembodied spirit – Aquinas explicitly rejects this interpretation of “spiritual”\(^{122}\) – but that in the resurrected life the soul will no longer be subject to the corruption of the body. In the “first generation of man” the soul, which is created by God and infused into the body’s matter, suffers the whims and decay of the body until the body’s eventual death. In the resurrection, however, the soul pre-exists the resurrection body, and the body is

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\(^{119}\) *SCG* IV.88.1-3.

\(^{120}\) *SCG* IV.88.5. In aetate autem Christi, quae est aetas iuvenilis, oportet omnes resurgere, propter perfectionem naturae quae in hac sola aetate consistit.

\(^{121}\) *SCG* IV.83.1-24.

\(^{122}\) *SCG* IV.86.5.
incorruptibly reconstructed “according to the condition of the incorruptible soul.” The soul will then have “perfect dominion over the body” with respect to its corruption – a good thing, for sure, if one’s soul is directed through cooperation with divine grace to its final end, God. In that case, through a superadded gift of grace, the body will become “entirely subject to the soul . . . not only in regard to its being, but also in regard to action, passion, movements, and bodily qualities.” Then, “just as the soul which enjoys the divine vision will be filled with a kind of spiritual lightsomeness, so by a certain overflow from the soul to the body, the body will in its own way put on the lightsomeness of glory.” Aquinas’ language for this embodied eschatological life is charged with energy and facility; the embodied soul in beatitude “will in all matters experience the fulfillment of desire,” resulting in the body’s “utter obedience to the spirit’s slightest wish.” The just, he writes, quoting the Wisdom of Solomon, “shall run to and fro like sparks among the reeds.”

Not so, however, for the resurrected bodies of the damned in whom the soul, in the first bodily life, turned away from God. Aquinas states that these bodies, though incorruptible, will not be entirely subject to the spirit. They will, instead, be “burdensome and heavy, and in some way hard for the soul to carry.” They will

123 *SCG IV*. 82.7. . . . secundum conditionem incorruptibilis animae.
124 *SCG IV*. 86.1. Erit enim totaliter subiectum animae, divina virtute hoc faciente, non solum quantum ad esse, sed etiam quantum ad actiones et passiones, et motus, et corporeas qualitates.
125 *SCG IV*. 86.2. Sicut igitur anima divina visione fruens quadam spirituali claritate replebitur, ita per quandam redundantiam ex anima in corpus, ipsum corpus suo modo claritatis gloriae induetur.
126 *SCG IV*. 86.3. Anima etiam quae divina visione fruetur, ultimo fini coniuncta, in omnibus experietur suum desiderium adimpletum. Et quia ex desiderio animae movetur corpus, consequens erit ut corpus omnino spiritui ad nutum obediat.
127 Ibid.; tanquam scintillae in arundineto discurrent.
128 *SCG IV*. 89.4. . . . ponderosa et gravia, et quodammodo animae importabilia.
remain capable of suffering, including the suffering of the frustration of their natural (and now eternally thwarted) desire for beatitude. They will be “dense and darksome” (opaca et tenebrosa).

From these sections of the Summa contra gentiles we may draw two preliminary conclusions regarding Aquinas’ treatment of the eschatological body. First, as stated previously, the life of the human person in beatitude is an embodied life; the body is therefore not just a vessel inhabited by the soul on the way to beatitude but is instead an eschatological participant in it. Second, however, the body is an important and integral part of the “spiritual” life of the person between birth and death; it is as an embodied being that the soul develops (or does not develop) the moral virtues which render the soul more open to the good, and as an embodied being that the soul, infused with the theological virtue of charity, finds (or does not find) itself gifted with infused moral virtues which super-orient any acquired moral virtues which exist, directing the soul to its final end in God. Because humans are embodied creatures and because cultivation of virtue (and vice) is an embodied activity which in part simply is the training (or lack thereof) of the body to move according to the true and the good as these are apprehended by the soul’s intellectual faculty, the character of the soul at death is in some way a marker of a lifetime’s training of the body. Aquinas’ eschatological construal leaves no room for duplicity: humans are made, in the resurrection, into who they have become

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129 SCG IV.89.6.

130 Michael Sherwin uses the example of a person with alcohol dependence newly converted to Christianity, behaviorally transformed and yet tormented by desires of yet another drink, as a case study to argue that the infused moral virtues can exist without presupposing the prior existence of acquired moral virtues. Sherwin, “Infused Virtue and the Effects of Acquired Vice: A Test Case for the Thomistic Theory of Infused Cardinal Virtues,” The Thomist 73 (2009):29-52.
during a lifetime of embodiment. A body-soul which is so preoccupied with bodily
desires so as to have lost sight of its final end in God will, in an eternity of futility, chase
those insatiable bodily desires. A body-soul which is, in grace, sufficiently aligned to its
final end in God will, for an eternity of delight, see its desires progressively fulfilled.

This, to be sure, raises many questions of the body’s relationship to the moral life
of the person, in particular about the relationship of bodily weakness, sickness, or injury
to the acquisition of virtue. We will take up these questions in the next chapter.
8 ‘Order Me Inwardly Through a Good Life’: The Body and Its Relation to Moral Agency

O Deus
omnipotens, omnia sciens,
principio et fine carens,
qui es virtutem
donator,
et conservator,
et remunerator,
digneris me
stabilire solido fidei fundamento,
et tueri inexpugnabili spei clipeo,

atque decorare nuptiali caritatis vestimento.

Da mihi
per justitiam
tibi subesse,
per prudentiam
insidias diaboli cavere,
per temperantiam
medium tenere
per fortitudinem
adversa patiener tolerare. . . .

Ordinare me digneris interius per bonam vitam,
ut faciam
quod deceat
et quod mihi proficiat
ad meritum
et reliquis proximis ad exemplum.

O God,
all-powerful and all-knowing,
without beginning and without end,
You Who are
the source,
the sustainer,
and the rewarder of all virtues,
Grant that I may
abide on the firm ground of faith,
be sheltered by an impregnable shield of hope,
and be adorned by the bridal garment of charity.
Grant that I may
through justice
be subject to you,
through prudence
avoid the beguilements of the devil,
through temperance
exercise restraint,
and through fortitude
endure adversity with patience. . .

Order me inwardly through a good life,
that I might do
what is right
and what will be
meritorious for me
and a good example for others.

--from St. Thomas Aquinas, “Prayer to Acquire the Virtues”

In Chapter Four of this work, I argued that psychiatric nosology requires some sort of teleology – some account of what it means for humans to flourish in a particular context – in order to render non-arbitrary judgment about “dysfunction of” a person in that context. I also argued that psychiatric nosology requires a method for demarcating *medical* failures of flourishing (e.g., dementia) from those which do not appropriately fit the medical model (e.g., ordinary vice). In Chapter Seven, I argued that a philosophy of psychiatry useful for Christian reflection on psychiatric technology must treat not only of the relation of mind and body and the nature of psychiatric causal explanation but must also situate the body in the context of the moral life of the person. In each of those discussions, I mentioned that Aquinas’ thought could provide helpful constructive resources, but I deferred detailed discussion until a later chapter. It is time to make good on these promissory notes.

Aquinas’ thought is indeed helpful in thinking through the relationship between the body and the moral agency of the person, and in this chapter I will describe his account of this, particularly in its most developed form in the *Summa theologiae*. For Aquinas, the human person – a unified substance of body and soul – is the *principium* of his or her action, and therefore a proper subject of the moral life. The human person’s habituation in virtue is, on the whole, an *embodied* habituation in which the body’s appetites are formed so that the person can pursue genuinely good things with the support of the rightly-formed passions. Both virtue and vice, I will argue, inscribe themselves on the body and are manifest in the passions. But the body, for Aquinas, can malfunction or fail to develop in ways that deeply implicate the embodied person’s capacity for
habituation. This can take several forms. Most paradigmatically, in the case of profound developmental disability, the sensitive faculties of the soul do not present the intellectual faculty with the phantasms requisite for higher-order deliberation and the moral culpability of the person for apparently vicious acts is correspondingly abrogated. In many cases, though, the situation is more mixed: less severe forms of disease, injury, or disability may affect the capacity for habituation in the moral life and therefore partially abrogate agency, but might also provide further opportunity for habituation in virtue.

In this chapter I will outline, in three stages, the contours of Aquinas’ treatment of the body’s relationship to the moral agency of the human person. First, I will briefly sketch Aquinas’ treatment of human freedom and moral agency and the body’s role within the achievement of that freedom. Second, I will touch on Aquinas’ expansive concept of vice (vitium), which incorporates both disease/sickness and sin, just as Aquinas’ expansive concept of virtue incorporates both health and moral rectitude. Understanding the relationship between sin and disease within this broader grammar of vice, however, is exceedingly complex, and I will present a blurry and interpenetrating “taxonomy” of three sorts of examples which show some of the breadth of Aquinas’ views of this relationship: cases in which bodily indisposition so impairs the exercise of the rational faculty so as to abrogate moral agency, in whole or in part (the amentes and furiosi); cases in which the body presents intrinsic limitation to the use of the rational faculty, yet not so as to abrogate moral agency entirely, and for which a gracious God has provided the sacraments (all humans); and cases in which participation in vice recursively changes the body so as to render future vicious action more likely (all humans to some
degree, but particularly those who are habitually inebriated). One might hope that such a taxonomy would be able to cleanly differentiate those whose failure-to-flourish is due to bodily indisposition (i.e., those with a brain injury) from those whose failure-to-flourish is due to non-bodily concerns (i.e., cultural learning, or deliberate vicious action). Unfortunately, I will argue, this is not the case: the vast majority of human failure-to-flourish (vice) is not due to bodily indisposition or non-bodily factors, but rather due to an inextricable combination of both: particular bodily configurations enable particular (but always limited) forms of agency, the exercise of which then alters these bodily configurations, which then modulate the available forms of agency, and so on. The consequence of this is that while Aquinas’ teleologically-oriented psychology can easily account for what it looks like not to flourish, there is no broadly applicable, straightforward way in Aquinas’ thought to differentiate medical from non-medical failures of flourishing. Because some might object that Aquinas’ treatment of “health” (sanitas), situated within his broader concept of natural good, would provide just such a criterion, I devote the third section of this chapter to demonstrating why that is not the case. Sanitas, it turns out, fails to provide clear demarcation of medical from non-medical failures of flourishing because there is no way to ascertain, without recourse to the behavior and subjective experience of the organism (its operation), whether a state of “health” exists. Health, then, like virtue in general, requires reference to operation and its absence is only recognizable in light of a failure of operation. What Aquinas does do, however, is to situate health and sickness within the broader grammar of virtue and vice,
and to lay important groundwork for prudential decision-making about the application of psychiatric technology.

8.1 The Structure of Embodied Moral Agency

It is essential to Thomas’ moral psychology that the human person is the principle (principium) of his or her action with a natural capacity of free choice (liberum arbitrium). This does not mean that the human is an absolute or unconstrained agent, with the “freedom of indifference” which Servais Pinckaers, citing William of Ockham, characterizes as a free will which precedes the rational and volitional powers so as to move them to their acts.2 Nor, for St. Thomas – and throughout this section I am heavily influenced by Pinckaers’ interpretation – is the will characterized by “radical indifference” to contraries.3 Nor, furthermore, does St. Thomas oppose human agency and freedom to the natural inclinations of the person, as if the body and its passions were essentially constraining and the noncorporeal powers were essentially liberating, with the consequence that freedom is to be found most perfectly in escape from the conditions of embodiment.

Aquinas’ account of the human liberum arbitrium in STh Ia q. 83 is in fact surprisingly modest. Invoking Jesus ben Sirach, he argues that “man has free-[decision]: otherwise counsels, exhortations, commands, prohibitions, rewards and punishments

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3 Ibid., 332.
would be in vain.”\textsuperscript{4} But his account of this is remarkably empirical and is hardly an *apologia* for voluntarism. Free-decision, he argues, names only the empirical truth that humans, unlike inanimate substances and (arguably, perhaps) unlike other animals, can be inclined to a certain act not (only) by “natural instinct” but (also) by “some act of comparison in the reason.” Humans, in other words, respond to persuasion as well as to coercion and can weigh various arguments in deciding how to order our action. But this requires, for Aquinas, some degree of indeterminacy in the structure of action in which reasons can play a role, and it is precisely this space which Aquinas labels *liberum arbitrium*.\textsuperscript{5}

For Aquinas this *liberum arbitrium* is neither incommensurate with nor diminished by the truth that the power of free-decision is itself moved by God (“just as by moving natural causes [God] does not prevent their acts being natural, so by moving voluntary causes [God] does not deprive their actions of being voluntary: but rather [God] is the cause of this very thing in them”\textsuperscript{6}) or that the power of free-decision cannot negate or change certain natural inclinations of the human, particularly the natural desire for happiness.\textsuperscript{7} Furthermore, although the power of *liberum arbitrium* is challenged by temperaments or dispositions of the body and the sensitive soul which incline a person to act in certain ways, Aquinas believes that the natural power of *liberum arbitrium* is not negated entirely (though he later allows for possible exceptions to this, which we will

\textsuperscript{4} *STh* Ia q. 83 a. 1 *resp.* . . . homo est liberi arbitrii, aliquoquin frustra essent consilia, exhortationes, praecepta, prohibitiones, praeemia et poenae.

\textsuperscript{5} Ibid.

\textsuperscript{6} *STh* Ia q. 83 a. 1 *ad3.* Et sicut naturalibus causis, movendo eas, non auffert quin actus earum sint naturales; ita movendo causas voluntarias, non auffert quin actiones earum sint voluntariae, sed potius hoc in eis facit . . .

\textsuperscript{7} *STh* Ia q. 83 a. 1 *ad5.*
explore below) because “these inclinations are [even so] subject to the judgment of reason” and because through the exercise of the rational faculty, humans can gradually acquire particular passions and habits which are conducive to reason or, conversely, can reject these passions and habits.⁸

Although the *liberum arbitrium* is an important component of Aquinas’ moral psychology, Aquinas clearly has no interest in building a voluntaristic moral theory. An unconstrained free will (that, for example, of the “freedom of indifference” which Pinckaers associates most paradigmatically with Ockham) is, for Aquinas, an oxymoron, for the simple and analytic reason that the will is, for Aquinas, always an appetitive power, pursuing whatever is presented to it as good (this is the point of Aquinas’ assertion that humans cannot will away the natural desire for happiness). The will, for Aquinas, can no more manufacture and rest in its own ends in general than the covetous man can manufacture and rest in money of his own creation.⁹ “The root of liberty is the will as the subject thereof; but it is the reason as its cause,” Aquinas writes, and therefore philosophers define the free-will as *liberum de ratione iudicium*, liberty of right reason.¹⁰ The will does not self-generate its freedom; it is, on the contrary, always restless, always seeking a good in which it can finally delight – a delight which can only be sustained, for Aquinas, when the will comes to rest, assisted by grace, in God and God’s good things.¹¹

Freedom in its most full form, for Aquinas, far surpasses the power of *liberum arbitrium*. To be truly free, for Aquinas, is not only to possess *liberum arbitrium* but also

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⁸ Ibid. . . . sed istae inclinationes subiacent iudicio rationis . . .
⁹ *STh IaIIae* q. 3 a. 4 *resp.*
¹⁰ *STh IaIIae* q. 17 a. 1 *ad2.* . . . radix libertatis est voluntas sicut subiectum, sed sicut causa, est ratio.
¹¹ *STh IaIIae* q. 3 a. 1 *resp.*
to develop virtuous habits which enable the person to pursue his or her deepest natural inclination for the good – to attain through cooperating in gift what Pinckaers refers to as “freedom for excellence.”

Aquinas succinctly and helpfully describes this “true freedom” when, prefacing his defense of the religious life and following St. Paul, he describes a “twofold servitude and a twofold freedom” (*duplex servitus et duplex libertas*) to sin (*peccatum*) or justice/rightness (*iustitia*), respectively. One can be a servant to sin or to justice, and to be a servant of one entails freedom from the other. But the natural inclination of the human is not neutral between these two powers:

> Nevertheless, since man, by his natural reason, is inclined to justice, while sin is contrary to natural reason, it follows that freedom from sin is true freedom (*vera libertas*) which is united to the servitude of justice, since they both incline man to that which is becoming to him. In like manner true servitude (*vera servitus*) is the servitude of sin, which is connected with freedom from justice, because man is thereby hindered from that which is proper to him.

Freedom from sin, he then repeats in response to an objection, “results from [the infused theological virtue of] charity which is poured forth in our hearts by the Holy Ghost . . . Hence it is written, *Where the Spirit of the Lord is, there is liberty.*”

True freedom, in other words, is for Aquinas a grace-enabled achievement which far surpasses the psychological capacity of *liberum arbitrium*. One can (and does) maintain the capacity of *liberum arbitrium* and yet can be (and is) bound in servitude to

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13 *STh IIaIIae q. 183 a. 4 resp.* Veruntamen, quia homo secundum naturalem rationem ad iustitiam inclinatur, peccatum autem est contra naturalem rationem, consequens est quod libertas a peccato sit vera libertas, quae coniungitur servituti iustitiae, quia per utrumque tendit homo in id quod est conveniens sibi. Et similiter vera servitus est servitus peccati, cui coniungitur libertas a iustitia, quia scilicet per hoc homo impeditur ab eo quod est proprium sibi.
14 *STh IIaIIae q. 183 a. 4 ad1.* . . . libertas a peccato fit per caritatem, quae diffunditur in cordibus nostris per spiritum sanctum, ut dicitur Rom. V, et inde est quod dicitur II ad Cor. III, *ubi spiritus domini, ibi libertas* [original scripture citations kept].
sin. Human persons are most fully free, however, when they have been liberated from sin for servitude to justice, actualizing both their natural desire for happiness and, through grace in the eschaton, the consummation of happiness in the life of God. Humans are free to the extent that they are not inclined to sin and are most fully free when, captivated by the vision of God’s goodness and beauty, they cannot sin, as Aquinas makes clear when arguing that beatified angels, who cannot sin because they see God through God’s essence, have greater freedom of will than any human wayfarer.\footnote{STh Ia q. 62 a. 8 ad3. Aquinas’ specific argument, a response to the objection that beatified angels can sin because they have no less free will than humans and “it belongs to the liberty of free-will for man to be able to choose good or evil,” is worth citing here: “Free-will in its choice of means to an end is disposed just as the intellect is to conclusions. Now it is evident that it belongs to the power of the intellect to be able to proceed to different conclusions, according to given principles; but for it to proceed to some conclusion by passing out of the order of the principles, comes of its own defect. Hence it belongs to the perfection of its liberty for the free-will to be able to choose between opposite things, keeping the order of the end in view; but it comes of the defect of liberty for it to choose anything by turning away from the order of the end; and this is to sin. Hence there is greater liberty of will in the angels, who cannot sin, than there is in ourselves, who can sin.” Liberum arbitrium sic se habet ad eligendum ea quae sunt ad finem, sicut se habet intellectus ad conclusiones. Manifestum est autem quod ad virtutem intellectus pertinet, ut in diversas conclusiones procedere possit secundum principia data, sed quod in aliquam conclusionem procedat praetermittendo ordinem principiorum, hoc est ex defectu ipsius. Unde quod liberum arbitrium diversa eligere possit servato ordine finis, hoc pertinet ad perfectionem libertatis eius, sed quod eligat aliquid diverso ab ordine finis, quod est peccare, hoc pertinet ad defectum libertatis. Unde maior libertas arbitrii est in Angelis, qui peccare non possunt, quam in nobis, qui peccare possimus.}

Aquinas’ association of liberty with the realization of the human telos deeply influences his description of human agency. The self-evident and limited capacity to choose between two or more means to a particular end – the capacity which Aquinas names as liberum arbitrium – is a precondition of the moral life, but agency in its fullest and most free sense stands not at the start of the moral and spiritual life but at its consummation. We have here a Christian interpretation of the Aristotelian gap, articulated by MacIntyre (see Chapter 4 of this work), between “[humanity]-as-it-happens-to-be” (for Thomas, endowed with a natural inclination to the good and a limited
decisional capacity but inexorably weakened by the effects of original sin and actual sin) and “[humanity]-as-it-would-be-if-it-realized-its-essential-nature” (for Thomas, free to realize its natural inclination for the good, and assisted by supernatural grace to its supernatural end in God). The path from the first to the second state is illuminated by ethics, which for Aquinas connotes the entire landscape of the acquired (moral) and infused (theological and moral) virtues. It is through habituation in virtue, and particularly as acquired moral virtues such as temperance, justice, fortitude, and prudence are themselves graced and formed by the infused theological virtue of charity (and hence turn out to be infused moral virtues, seeking God and not only the natural human good as their end) that the human person becomes most fully free.

Readers may wonder, at this point, what any of this has to do with the body. In fact, it might seem that Aquinas conceives of the moral and theological virtues completely in abstraction from the body. The liberum arbitrium, after all, is described as a uniquely human endowment and therefore a part of the rational, noncorporeal faculty of the soul, and the ensuing discussion about grace and the virtues would seem to lead to a progressively disembodied, rather than an embodied, understanding of the moral life. Aquinas, in fact, seems to reinforce this perception in his discussion of habits and the virtues. Stipulating “habit” as a quality, difficult to change, whereby that which is disposed, is disposed either well or ill, either to its form or to its act, Aquinas seems to introduce a distinction between what later came to be referred to as entitative habits.

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16 Alasdair MacIntyre, After Virtue: A Study in Moral Theory, 2nd ed. (Notre Dame, Ind.: Univ. of Notre Dame Press, 1984), 52.
17 STh IaIae q. 65 a. 2 resp.
which properly dispose matter to its form, and *operative* habits, which properly dispose a
form to its act.\textsuperscript{18} Health (*sanitas*), he holds, is an [entitative] habit which disposes the
body to its form (though there are problems with this characterization, which we will
discuss in more detail below).\textsuperscript{19} The moral virtues, on the other hand, are operative
habits which dispose the soul, as the principle of action, to its proper act. Aquinas even
elaborates that “human virtue . . . cannot belong to the body, but belongs only to that
which is proper to the soul,” for the reason that the moral virtues are not shared with the
brute animals and, therefore, cannot inhere in the conditions of embodiment which are
shared with the animals but must properly reside in the rational soul.\textsuperscript{20} So it would seem
from this that virtue inhere in the soul, not in the body, and that to speak of “embodied
moral agency” is, for Aquinas, an oxymoron.

But it is not. Despite Aquinas’ insistence that the virtues properly reside in the
soul, of which the primary function is to safeguard human uniqueness among the non-
ational animals, he makes clear that the body everywhere pertains to and sometimes is
an essential participant in the life of virtue, and therefore in the attainment of agentic
freedom. This is emphasized even at the point of his initial distinction between the
operative and non-operative [entitative] habits, where after positing that “insofar as habit
implies disposition to operation, no habit is principally in the body as its subject,” he
provides an important nuance:

\textsuperscript{18} Robert Brennan, *Thomistic Psychology: A Philosophic Analysis of the Nature of Man* (New York: MacMillan, 1941), 263.
\textsuperscript{19} *STh* lIaIIae q. 50 a. 1 *resp.*
\textsuperscript{20} *STh* lIaIIae q. 55 a. 3 *resp.*

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As to the operations which proceed from the soul through the body, they belong principally to the soul, and secondarily to the body. Now habits are in proportion to their operations: whence by like acts like habits are formed (Ethic. ii. 1, 2). And therefore the dispositions to such operations are principally in the soul. But they can be secondarily in the body: to wit, insofar as the body is disposed and enabled with promptitude to help in the operations of the soul.  

The assertion that the body may be “disposed and enabled with promptitude to help in the operations of the soul” immediately challenges any firm and rigid distinction between the operative (pertaining to the soul) and entititative (pertaining to the body) habits, for the simple reason that Aquinas does not hold, contra later dualists, that human psychological function can be understood in toto independently of the body (as explored in the last chapter). The operative habits of the soul, that is, imply the proper disposition of matter to its form; and (as we will explore later in this chapter, with regard to health) the entitative habits of the body are intelligible only insofar as they enable the body-soul to be disposed to its proper act. For Aquinas this is true particularly with regard to the function of the sensitive part of the soul, which depends for its function on bodily operation. Aquinas holds that because the sensitive powers can act “at the command of reason” (ex imperio rationis), they can properly be the subject of habit even though they are shared with the non-rational animals and are embodied.  

He then later elaborates, following Aristotle (Nic. Ethic. iii. 10) that the (embodied) irascible and concupiscible powers of the sensitive soul can be the subject of virtue, not considered in themselves (apart from the rational faculty), but insofar as they are moved by reason, such that “the

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21 STh IaIIae q. 50 a. 1 resp. Operationes vero quae sunt ab anima per corpus, principaliter quidem sunt ipsius animae, secundario vero ipsius corporis. Habitus autem proportionantur operationibus, unde ex similibus actibus similes habitus causantur, ut dicitur in II Ethic. Et ideo dispositiones ad tales operationes principaliter sunt in anima. In corpore vero possunt esse secundario, inquantum scilicet corpus disponitur et habilitatur ad prompte deserviendum operationibus animae.

22 STh IaIIae q. 50 a. 3 resp.
virtue which is in the irascible and concupiscible powers is nothing else but a certain
habitual conformity of these powers to reason.”\textsuperscript{23} The sensitive powers can embody
virtue insofar as they are “rational by participation” (rationales per participationem).\textsuperscript{24}

It is tempting to fall in to dualistic language to speak of this relationship of body
and soul, as Aquinas himself does when, following Aristotle, he argues that the soul rules
the body with a despotic rule but that the reason rules the irascible and concupiscible
powers, which “have their own proper movements, by which, at times, they go against
reason,” by a political command.\textsuperscript{25} But these comparisons, even for Aquinas, are
imperfect metaphors. The soul cannot \textit{really} rule the body as a master rules a servant, not
only for the obvious reason that human servants do not always do their masters’ bidding
but also because human servants are complete substances while the body, abstracted from
the soul, is not. The soul is the act of the living human body; the body is that which is
acted upon; neither are intelligible, under the condition of embodied life, apart from the
other. To get at this unity, also metaphorically, we might allow ourselves to imagine a
pair of champion figure-skaters (I will avoid gender-specificity here) in which one is
clearly leading and the other is responding, gracefully and synchronously, to the
prompting of the first. But as the routine progresses, as they interweave and complement
each other, the audience forgets that they are two separate persons. They become one act,
an act which cannot be described or understood with reference to either of them alone, an
act of compelling beauty and complexity and vibrancy. It is no longer even clear who

\textsuperscript{23} STh IaIIae q. 56 a. 4 \textit{resp.} ideo virtus quae est in irascibili et concupiscibili, nihil aliud est quam
quaedam habitualis conformitas iatarum potentiuarum ad rationem
\textsuperscript{24} STh IaIIae q. 56 a. 4 \textit{ad1}.
\textsuperscript{25} STh IaIIae q. 56 a. 4 \textit{ad3}. Sed irascibilis et concupiscibilis . . . habent proprios motus suos, quibus
interdum rationi repugnant
leads and who responds, as they each depend on and respond to each other in a seemingly effortless (and exquisitely well-habituated) flow. To say that the one who follows does not share in this act is transparently false, as only in the context of his or her graceful participation in the act is the act itself properly manifest. It is something like this, for Aquinas, which names how the body participates in virtue and how virtue requires proper habituation of the body.  

The psychophysiological nexus of this embodied participation in virtue is, for Aquinas, the passions. The passions occupy a crucial place in the organization of the *Prima Secundae* of the *Summa* (IaIIae qq. 22-48), after the discussions of beatitudo and the basic structure of practical reason (IaIIae qq. 1-21) and before the elaborations of habit (qq. 49-54), virtue (qq. 55-70), sin (qq. 71-89), law (qq. 90-108), and grace (qq. 109-114). Aquinas does not invent the concept of the passions – as with much else in his moral psychology, he inherits it from classical thought via Aristotle and Augustine27 -- but he systematically incorporates them into his moral theory in an unprecedented way. Aquinas struggles with whether the passions properly inhere in the soul – he initially allows only that passions resulting in the loss of some perfection in the body-soul composite inhere in the soul only accidentally28 – but it is clear, for him, that the passions entail “corporeal transmutation” (*transmutatio corporalis*) and therefore, insofar as they

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26 This metaphor is, of course, limited as a picture of Aquinas’ theory. It is clear, for example, that body and soul are not ontologically equivalent, as two figure-skaters are; the soul relates to the body as form to matter, not as leader to follower. But since Thomas himself, as described above, uses metaphorical language (such as ruler and subjects) to describe the soul’s relationship to the body, such modern metaphorical gesturing does not seem entirely inappropriate.

27 *STh* IaIIae q. 22 a. 2 *sed contra*.

28 *STh* IaIIae q. 22 a. 1 *resp.*.
inhere in the soul, inhere in the sensitive appetites.\textsuperscript{29} Furthermore, the passions entail being moved by some external agent. (It is for this reason that the English “passion,” transliterated from \textit{passio}, by entailing an agent, is much to be preferred to the more common term “emotion,” which does not so entail an agent.) The passions, because they imply a \textit{movement by} something, are therefore always \textit{about} something; they have a directedness which points beyond themselves to that mover to which they stand as sign.

What are these “somethings” which move the body in such a way as to give rise to the passions? They are, simply, other things, \textit{as interpreted by} the animal as good or evil for it. Although I do not intend here to provide a detailed account of Aquinas’ taxonomy of the passions,\textsuperscript{30} a cursory introduction is necessary for making sense of his moral psychology. An object might be apprehended as good or evil, for Aquinas, in one of two ways. It might be apprehended as good (pleasurable) or evil (painful) as such (\textit{simpliciter}) or might be apprehended as good or evil the acquisition or avoidance of which will involve struggle. If an object is apprehended as good (pleasurable) or evil (painful) as such, it will effect the passions of the concupiscible faculty; if, on the other hand, the object is apprehended as good or evil which has “an arduous or difficult nature,” it will effect the passions of the irascible faculty.\textsuperscript{31} The concupiscible faculty, being that faculty which is concerned which things which are interpreted as immediately good (pleasurable) or evil (painful), is fairly uncomplicated. Objects interpreted as good

\textsuperscript{29} \textit{STh} IaIIae q. 22 a. 3 \textit{resp.}


\textsuperscript{31} \textit{STh} IaIIae q. 23 a. 1 \textit{resp.}
simpliciter will evoke one of three passions: love (amor), which is the presupposition of all other passions\textsuperscript{32} and which simply names the propensity of the body-soul to find its natural dwelling-place (complacentia) in the good and which therefore initiates the movement of union with that which is good;\textsuperscript{33} desire (concupiscentia), which is the love-initiated craving (appetitus) for the not-yet-attained good and/or movement toward it;\textsuperscript{34} or delight (delectatio), which occurs when the sensitive faculty attains, or comes to rest in, the desired good object.\textsuperscript{35} Objects interpreted as evil simpliciter will evoke one of three corresponding passions: hatred (odium), which is a dissonance (dissonantia) within the soul from that which is apprehended as evil;\textsuperscript{36} avoidance (fuga), which is the movement of the body-soul away from that which is detested;\textsuperscript{37} or pain (dolor) or sorrow (tristitia), which occur in the ongoing presence of the detested and hated object.\textsuperscript{38} The irascible faculty is, in contrast with the concupiscible faculty, more complex. Objects interpreted as good which are at the same time interpreted as difficult to acquire will evoke one of two passions within the embodied irascible appetite: hope (spes), which “denotes a certain stretching out of the appetite towards good” and is “the movement of the

\textsuperscript{32}STh IaIIae q. 27 a. 4 resp.
\textsuperscript{33}STh IaIIae q. 26 a. 1 resp.; STh IaIIae q. 28 aa. 1-3.
\textsuperscript{34}STh IaIIae q. 30 a. 1 resp. ad3.
\textsuperscript{35}STh IaIIae q. 31 a. 3 resp.
\textsuperscript{36}STh IaIIae q. 29 a. 1 resp.
\textsuperscript{37}STh IaIIae q. 23 a. 4 resp. Interestingly, Aquinas pledges to treat aversion in more detail in the prologue to q. 26, noting that in his consideration of the passions of the concupiscible faculty, “we will consider love and hatred, desire and aversion, pleasure and sadness” STh IaIIae q. 26 prooemium. Curiously, he never mentions fuga again in his discussion of the passions.
\textsuperscript{38}STh IaIIae q. 35 a. 2 resp. For Aquinas pain and sorrow/sadness are closely related, with pain related to sorrow as delight is related to joy. Pain, for Aquinas, occurs whether the feared object is apprehended through the external senses or through the interior apprehension of the intellect or of the imagination. Sorrow (tristitia) is limited to objects apprehended through interior apprehension. Sorrow is therefore a species of pain. Although I do not develop it here, this formulation seems to have very helpful and practical implications for contemporary pain studies, specifically around the “psychosomatic” nature of pain. See, for a non-Thomistic discussion, Sarah Coakley and Kay Kaufman Shelemay, eds., Pain and Its Transformations: The Interface of Biology and Culture (Cambridge, Mass.: Harvard Univ. Press, 2008).
appetitive power ensuing from the apprehension of a future good, difficult but possible to obtain;” or despair (desperatio), which results when the arduous good is perceived as unattainable. Finally, objects interpreted as evil but which are at the same time interpreted as difficult to avoid will evoke one of three passions which also inhere in the irascible appetite: fear (timor), which is a contraction (contractio) of the body-soul in the presence of a difficult-to-avoid evil; daring (audacia), which conversely is the stretching out of the body-soul in the face of a difficult-to-avoid evil in the hope of overcoming it; or anger (ira), which arises in the sustained presence of a difficult-to-avoid evil and seeks for justice and vengeance against it.

For Aquinas all of these passions involve bodily transmutation, and (as touched on in Chapter 6 of this work) he is not shy about accounting for that transmutation in the terms of the Aristotelian/Galenic four-humor biology which was the most advanced science of his time. In the sorrowful person, the body is “corroded by a base humor;” one can be naturally disposed to anger “due to a bilious temperament; and of all the humors, the bile moves quickest, for it is like fire;” in fear, there is a “contraction of heat and vital spirit towards the inner parts.”

39 StTh IaIIae q. 40 a. 2 resp. importet extensionem quandam appetitus in bonum . . . motus appetitivae virtutis consequens apprehensionem boni futuri ardui possibilis adipisci . . .
40 StTh IaIIae q. 40 a. 4 resp. ad3. Aquinas clarifies that despair entails not only the absence of hope but also, naturally, a recoil from the hoped-for thing.
41 StTh IaIIae q. 41 a. 1 resp.
42 StTh IaIIae q. 45 a. 1 resp.
43 StTh IaIIae q. 46 a. 1 resp.
44 StTh IaIIae q. 32 a. 7 resp.
45 StTh IaIIae q. 46 a. 5 resp. Est enim homo dispositus ad irascendum, secundum quod habet cholericam complexionem, cholera autem, inter alios humores, citius movetur; assimilatur enim igni . . .
46 StTh IaIIae q. 44 a. 1 resp. contractio caloris et spirituum ad interiora
At the same time, however – and this is the crucial point – for Aquinas the passions are not only bodily transmutations. They are, rather, bodily transmutations with an inexorable aboutness; the transmutations occur as the body-soul encounters valuationally salient objects (external sensible objects, intellectual objects, or memories of objects no longer present). The passions are not independent of how a person inhabits his or her world; in fact, they stand as signs of what he or she apprehends as good and evil simpliciter and what he or she apprehends as arduous good and arduous evil. They are both subject-referring and object-referring, though reducible to neither. Looking at what someone loves, hates, desires, avoids, delights in, is pained by, hopes for, fears, is angered by, and so on – all bodily transmutations – reveals much about how the world appears to him or her.

What appears good to the person, of course, may not be what is good in the light of the human telos, and this brings us back, full circle, to the question of virtue and freedom. None of the passions, considered in themselves, are intrinsically virtuous or, with the possible exception of despair, intrinsically vicious; rather, they become virtuous or vicious, they incorporate themselves into the structures of virtue or vice, insofar as they both reflect and guide correct interpretation of the proper good. For Aquinas, as in the metaphor of the figure-skaters considered above, this habituation into virtue paradigmatically involves such nuanced and harmonious interplay of the body and the soul that it is hard to tell, except in a formal sense, which is leading and which is following. Responding to the objection of the Stoics that every passion of the soul is evil,
Aquinas states that this would be true if “passion” were to denote only inordinate movement of the soul,

but if we give the name of passions to all the movements of the sensitive appetite, then it belongs to the perfection of man’s good that his passions be moderated by reason. For since man’s good is founded on reason as its root, that good will be all the more perfect, according as it extends to more things pertaining to man. Wherefore no one questions the fact that it belongs to the perfection of moral good, that the actions of the outward members be controlled by the law of reason. Hence, since the sensitive appetite can obey reason, as stated above, it belongs to the perfection of moral or human good, that the passions themselves also should be controlled by reason. Accordingly just as it is better that man should both will good and do it in his external act, so also does it belong to the perfection of moral good, that man should be moved unto good, not only in respect of his will, but also in respect of his sensitive appetite, according to Ps. 58.3: My heart and my flesh have rejoiced in the living God: where by heart we are to understand the intellectual appetite, and by flesh the sensitive appetite.47

Such, at, least, is Aquinas’ ideal of psychological function; it is a thing of beauty and complexity, energetic and unmistakably erotic, as when he writes, citing the same verse from the Psalms, that a craving (appetitus) in the higher part of the soul for wisdom (sapientia) sometimes becomes so intense that there is overflow (redundantia) from the higher part of the soul to the lower appetites, such that following the lead of the higher appetite, “the body itself renders its service in spiritual matters.”48

47 STh IaIIae q. 24 a. 3 resp. Sed si passiones simpliciter nominemus omnes motus appetitus sensitivi, sic ad perfectionem humani boni boni pertinet quod etiam ipsae passiones sint moderatae per rationem. Cum enim bonum hominis consistat in ratione sicut in radice, tanto istud bonum erit perfectius, quanto ad plura quae homini conveniunt, derivari potest. Unde nullus dubitat quin ad perfectionem moralis boni pertineat quod actus exteriorum membrorum per rationis regulam dirigantur. Unde, cum appetitus sensitivus possit obediare rationi, ut supra dictum est, ad perfectionem moralis sive humani boni pertinet quod etiam ipsae passiones animae sint regulatae per rationem. Sicut igitur melius est quo homo et velit bonum, et faciat exteriori actu; ita etiam ad perfectionem boni moralis pertinet quod homo ad bonum movetur non solum secundum voluntatem, sed etiam secundum appetitum sensitivum; secundum illud quod in Psalmo LXXXIII, dicitur, cor meum et caro mea exultaverunt in Deum vivum, ut cor accipiamus pro appetitu intellectivo, carnem autem pro appetitu sensitivo.

48 STh IaIIae q. 30 a. 1 ad2. The entire text of the response is as follows: Ad primum ergo dicendum quod appetitus sapientiae, vel aliorum spiritualium bonorum, interdum concupiscencia nominatur, vel propter similitudinem quandam, vel propter intentionem appetitus superioris partis, ex quo fit redundantia in
freedom for excellence emerging from the life of virtue belongs not only to the soul but also to the body, or more properly to the body-soul composite, as the body learns to respond, habitually, to the nuanced direction of reason and of grace.

8.2 Disorders of Embodied Agency: A Taxonomy

Aquinas was well aware, of course, that the embodied life of the viator approximates only rarely, if ever, the paradigmatic harmonious unity of body and soul oriented toward beatitude. Life, after all, is not generally like that. For every pair of champion figure-skaters who briefly embody harmonious perfection, there are countless others whose act is marked not by perichoretic unity but by miscue, injury, disease, impatience, and various other forms of misfortune and malfunction. Aquinas was no Pelagian and was not optimistic about the means to which humans put their natural capacities, considered as a whole; although humans from conception retain their natural desire for happiness – however inchoate and thwarted that might be – they bear the stain of original sin, unable consistently to know and to do the good apart from habituation in virtue and, crucially, the superaddition of grace.49 Furthermore, though not unrelated, humans are corporeal animals: animals gifted with an intellectual faculty, to be sure, but animals nonetheless, prone to the same sorts of breakdowns, blow-ups, malfunctions, and contingencies as any other creature which depends for its psychological function on the co-operation of matter.

inferiorem appetitum, ut simul etiam ipse inferior appetitus suo modo tendat in spirituale bonum consequens appetitum superiorem, et etiam ipsum corpus spiritualibus deserviat; sicut in Psalmo LXXXIII, dicitur, cor meum et caro mea exaltaverunt in Deum vivum.

49 STh IaIae q. 86; IaIae q. 85 a. 5 resp.
For Aquinas the umbrella concept describing human disposition to breakdowns, blowups, and malfunctions is vice (*vitium*). Although this term is impossible to use in contemporary English without moralistic connotations, Aquinas is clear that the presence of vice in itself implies nothing about its cause. “The vice of a thing,” he writes, “seems to consist in its not being disposed in a way befitting its nature.”\(^{50}\) A thing’s nature, he later elaborates, is “chiefly the form from which that thing derives is species,” and since humankind derives its species from the rational faculty of the soul, “consequently whatever is contrary to the order of reason is, properly speaking, contrary to the nature of man, as man.”\(^{51}\) To most fully realize human nature is, for Aquinas, to live a life which participates in reason (*ratio*, as discussed below, is for Aquinas a teleological concept which signifies much more than discursive capacity), to live a life which aims at that which is good and avoids those things which distract from the good. Because the practical content of the good life cannot be known through *a priori* deduction alone but also (necessarily) through habituation in the virtues, the life lived according to reason is, for Aquinas, the life of virtue. So virtue names habituation to the proper human good which is also the natural human good— the virtuous human, for Aquinas, most properly

\(^{50}\) *STh* IaIIae q. 71 a. 1 *resp.* *vitium enim uniuscuiusque rei esse videtur quod non sit disposita secundum quod convenit suae naturae*

\(^{51}\) *STh* IaIIae q. 71 a. 2 *resp.* Full citation is as follows: *Sed considerandum est quod natura uniuscuiusque rei potissime est forma secundum quam res speciem sortitur. Homo autem in specie constituitur per animam rationalem. Et ideo id quod est contra ordinem rationis, proprie est contra naturam hominis inquantum est homo; quod autem est secundum rationem, est secundum naturam hominis inquantum est homo.*

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participates in the human form as a rational animal – and vice names habit which
disposes toward privation from virtue.\(^5^2\)

In addressing directly the question of whether vice is contrary to virtue in the
*Summa theologiae*, Aquinas makes clear that both virtue and vice were, in his time,
debated and polyvalent concepts. On one hand, it would seem that the opposites of virtue
are sin (*peccatum*) and malice (*malitia*) and that vice, which applies to “undue disposition
of bodily members or of any things whatever (*indebita dispositio membrorum
corporalium, vel quarumcumque rerum,*” might be too broad a concept.\(^5^3\) On this
account, that is, vice was taken as a broad concept which could well include bodily
dysfunction apart from sin. On the other hand, Cicero had written that “virtue is the
soul’s health (*virtus est quaedam sanitas animae,*” and so it would seem that sickness
(*aegritudo*) or disease (*morbus*), rather than vice, was most properly the contrary of
virtue.\(^5^4\) Aquinas, characteristically perhaps, responds in a way which attempts to satisfy
each of these contrary parties and, in so doing, leaves the concepts of virtue and vice
quite broad. He follows Aristotle’s definition of virtue as a disposition whereby the
subject is well-disposed according to the mode of its nature, and therefore vice, which

\(^5^2\) Aquinas’ overarching concept for the privation of good is, of course, *malum* (evil). In *STh Ia* q. 48 a. 5, he distinguishes between penal evil (*malum poenae*) and culpable evil (*malum culpae*). Penal evil, he writes, is the subtraction of the form, or any part required for the integrity of a thing (e.g., blindness, amputation). Culpable evil, in contrast, is the withdrawal of the proper operation of a thing, which is imputed as fault in rational beings. His later discussion of *vitium* in the *Secunda pars* maps imperfectly onto this distinction of the two forms of evil. *Vitium* is specifically a *disposition* to evil, or an evil habit (*STh IaIIae* q. 54 a. 3 resp.). However, if one reads *STh* IaIIae q. 71 a. 1 ad3 (cited in the next paragraph) to state that disease (*morbus*) and sickness (*aegritudo*) can be modes of *vitium*, then it seems clear that *vitium* overlaps *malum culpae* and *malum poenae*.

\(^5^3\) *STh* IaIIae q. 71 a. 1 obj. 1.

\(^5^4\) *STh* IaIIae q. 71 a. 1 obj. 3.
simply names the lack of this, is the direct contrary of virtue.\textsuperscript{55} Sin, as an inordinate (voluntary) human act,\textsuperscript{56} is contrary to that to which virtue is ordained, which is ordinate human action, directed to the good. Malice (evil residing in the will) is contrary to the consequence of virtue, which is to be a kind of goodness.\textsuperscript{57} He is clear, however, in response to Cicero, that disease and sickness is one mode of vice, though not the only one:

But vice of the soul, as Cicero says, is a habit or affection of the soul discordant and inconsistent with itself through life: and this is to be found even without disease and sickness, e.g. when a man sins from weakness or passion. Consequently vice is of wider extent than sickness or disease; even as virtue extends to more things than health; for health itself is reckoned a kind of virtue.\textsuperscript{58}

In this formulation that health is a \textit{kind} of virtue and that disease/sickness which impacts the ability of the human to act in accord with reason is a kind of vice, Aquinas makes clear that neither health nor disease/sickness are intelligible apart from the larger concepts of virtue and vice, which are for Aquinas essentially teleological concepts.

Virtue is the disposition of the human to operate as humans are supposed to operate, and health, which we will discuss further below, is a part of virtue; vice is disposition toward failure of proper operation, and disease is one such disposing condition. But health takes its form and gains coherence only within the broader logic of virtue, and disease takes its form within the broader logic of vice.

\textsuperscript{55} \textit{STh} IaIIae q. 71 a. 1 \textit{resp}. Directe quidem virtus importat dispositionem quandam alicuius convenienter se habentis secundum modum suae naturae. . .

\textsuperscript{56} \textit{STh} IaIIae q. 1 a. 1 \textit{resp}; q. 71 a. 6 \textit{resp}.

\textsuperscript{57} \textit{STh} IaIIae q. 71 a. 1 \textit{resp}.

\textsuperscript{58} \textit{STh} IaIIae q. 71 a. 1 \textit{ad3}. \textit{Sed vitium animi}, ut Tullius ibidem dicit, \textit{est habitus aut affectio animi in tota vita inconstans, et a seipsa dissenstis}. Quod quidem inventur etiam absque morbo vel aegrotatione, ut puta cum aliquis ex infirmitate vel ex passione peccat. Unde in plus se habet vitium quam aegrotatio vel morbus, sicut etiam virtus in plus se habet quam sanitas, nam sanitas etiam quaedam virtus ponitur . . .
Such, therefore, is the exegetical basis within Thomas’ own work for the Thomistic claim in Chapter 4 that psychiatric nosology displays and requires some form of teleology. But this way of categorizing vice and disease immediately raises the thornier and much less evident, though crucially important, question of how Aquinas demarcates the vice of disease from vice from other causes (in the example above, weakness or the passions). In other words, to return to the wording of Chapter 4, how does Aquinas demarcate what I have referred to as medical failures of flourishing from what I have referred to as non-medical failures of flourishing?

The short, and perhaps disappointing, answer is that he doesn’t in any systematically consistent way. There is, for Aquinas, no clear line between medical failures of flourishing and non-medical failures of flourishing, however important this distinction might be for his penitential moral theology. In retrospect it would be inappropriate to expect any rigid boundary, since this would be difficult to reconcile with Aquinas’ basic and consistent teaching that humans are embodied moral agents and that well-functioning moral agency reflects adequate functioning of the body.

What Aquinas does provide in the *Summa theologiae* are multiple examples of various bodily configurations, with commentary on how these configurations relate to the embodied person’s moral agency. Through these examples we can learn a great deal about how Aquinas understands the relationship between bodily contingency and agency, in ways that will prove useful, in this chapter and the next, for reflection on contemporary psychiatric nosology. We will consider three sets of examples here: states in which the body is unable to support the function of the intellectual faculty and moral agency *per se*
is abrogated; states in which the body limits the intellectual faculty’s discursive function; and states in which actions of the person have resulted in changes to the body which render further virtuous action more difficult. Such an analysis will provide a rough taxonomy, though as we will see, there are often no distinct or uncontroversial boundaries between these categories.

8.2.1 The Amentes and Furiosi: Abrogation of Moral Agency on Account of Bodily Indisposition

Scattered throughout Aquinas’ corpus are examples, generally invoked to illustrate a larger philosophical or theological point, of persons who, because of malformation, injury, or sickness to the body, do not have full use of the intellectual faculty of the soul and therefore find their moral agency commensurately abrogated. Aquinas usually refers to these persons variably as furiosi, amentes, idiotae, fatui or insani, as well as by other names, and as the 1911 Fathers of the English Dominican Province usual translations of these words – “madmen,” “imbeciles,” “idiots” – are themselves antiquated and (in our time) irreversibly pejorative, I will leave these words untranslated in my exposition here.

Although the exact conditions of those who met these description for Aquinas is debated, it is reasonable to believe that these categories would include, at a minimum,

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59 My interest in and consideration of Aquinas’ treatment of these persons has been strengthened through conversation with and engagement with the work of Miguel Romero, whose book chapter manuscript “Aquinas on the corporis infirmitas: Broken Flesh and the Grammar of Grace,” describes Aquinas’ treatment of the profoundly disabled in much more detail than does my relatively brief treatment here.

60 George Mora, “Thomas Aquinas and Modern Psychology: A Reassessment,” Psychoanalytic Review 64 (1977) 495-530; Vesa Hirvonen, “Mental Disorders in Late Medieval Philosophy and Theology,” in Mind
those with severe or profound intellectual disability, those with severe brain injury, and those with intractable psychosis. Because Aquinas generally refers to them casually and without introduction or exposition, it is reasonable to think that these persons would have been familiar to his intended readers – an out-grouped set of “others,” to be sure, and yet a group sufficiently integrated into family and community life that (arguably unlike our own time) they were not so marginalized as to be rendered invisible. In an era in which birth anoxia and childhood disease would have been more common, in which mass institutionalization of the mentally impaired had not yet become commonplace, and in which, of course, there were no reliable treatments for chronic psychosis, such persons would likely have been a familiar presence in every community.

Aquinas holds that the distinguishing difference of the *amentes* and *furiosi* is not the absence of a rational soul (an absence which would exclude the person from human nature) but, rather, a “bodily impediment” (*impedimentum corporale*) precluding the use of the intellectual faculty which, as with all human persons, is granted directly by God in creation. The intellectual faculty, that is, depends on the proper operation of the embodied sensitive faculty of the soul for, among other things, the reliable generation of phantasms (see Chapter 7). In the case of bodily injury, malformation, or disease, the sensitive faculty does not generate reliable phantasms and the active intellect, as a result, cannot abstract the universal forms which are the necessary currency of its operation.

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61 STIa q. 84 a. 4 *resp.*; Ia q. 84 a. 7 *resp.*; Ia q. 84 a. 8 *sed contra, resp., ad2.*; IaIIae q. 15 a. 1 *resp.*.  
62 STIa q. 45 a. 5 *ad3.*; IIIa q. 68 a. 12 *ad2.*;
Because the *amentes* and *furiosi* do not have proper use of the intellectual faculty, Aquinas holds that their behaviors are not, in Aquinas’ way of speaking, “human actions” – a technical term for Aquinas implying a “deliberate will,” not a boundary-marker for distinguishing the human from the non-human.\(^63\) Because of this, just to the degree that the intellectual faculty is impaired, moral agency (and therefore culpability) is correspondingly abrogated. This is clear throughout the *Summa theologiae*, both in Aquinas’ discussion of specific sins such as fornication\(^64\) and in his more general discussions of agency, when he uses the *amentes* and *furiosi* as examples of those who are excused from sin altogether because of impaired agency.\(^65\)

Aquinas’ description of the *amentes* and *furiosi*, together with his assertion that the *imago dei* properly resides in the human capacity for reason and will (given in the right function of the intellective faculty),\(^66\) has prompted criticism among “disability theologians,” chief among them Hans Reinders, who charges that Aquinas (following Augustine, and prefiguring modern Catholic moral theology) relegates persons with profound intellectual disability to a marginalized, barely-human class. Reinders charges that contemporary Catholic moral theology attempts to ground human personhood in the biological context of human parentage, and yet marginalizes intellectually disabled persons by narrating the human *telos* as the realization of the rational capacities of intellect and will:

\(^{63}\) *STh IaIIae* q. 1 a. 1 *resp.*  
\(^{64}\) *STh IaIIae* q. 88 a. 6 *ad2.*  
\(^{65}\) *STh IaIIae* q. 76. a. 3 *ad3*; *STh IaIIae* q. 154 a. 5 *resp.*  
\(^{66}\) *STh Ia* q. 93 a. 2 *resp.*
What we are left with, then, is a question of the relationship between two claims, one regarding the genesis, or origin, of being human, the other regarding its telos, or ultimate end. The first is the claim that every human being, regardless of his state or condition, is to be regarded as a person from the moment of conception because he is of human parentage; the second is the claim that the end of being human is the fulfillment of our natural being that consists in the perfection of the capacities of reason and will. The tension between these two claims becomes evident when we look at them from the perspective of human beings lacking in these capacities. It is difficult to avoid the conclusion regarding the second claim, that is, that the lives of these human beings could be anything but “subhuman.”

Specifically linking this tradition to Augustine and Aquinas, Renders writes that “while [for these thinkers] all human beings are doubtless human according to their origin, some human beings are only human in a marginal sense from the point of view of their final end.” Identification of realized human nature with rationality, that is, implicitly marginalizes those who do not have use of the rational function.

Reinders and other theologians of disability raise important and troubling questions regarding patterns within Christian theology which have marginalized the intellectually and physically disabled, primarily by portraying persons with disability as objects of Christian pity and charity and therefore rendering them instrumental to the sanctification of those who are not so disabled. It is not my intent here to engage in detailed evaluation of this movement. I do briefly wish to suggest, however, that Aquinas’ depiction of the amentes and furiosi is more complex than is often narrated.

First, in a discussion which does not significantly challenge Reinders’ analysis, Aquinas

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makes clear that speaking ill of the *amentes* with intent to shame them is a mortal sin.\textsuperscript{69} Second, however, we should remember that the rational life for Aquinas is not a life marked by vigorous mental activity in a person with a high intelligence quotient, with dazzling display of discursiveness; it is rather the life which is lived in conformity with God’s *ratio*, as that *ratio* participates the life of the rational creature.\textsuperscript{70} Human *ratio*, for Aquinas, is not limited to discursive cognitive act; it is also (and more broadly) a teleological concept, signifying participation of the human in God’s *ratio*. While it is true that humanity (considered as a whole, across time) could not collectively participate the eternal law apart from the God-granted capacity to apprehend divine truth granted in the intellectual faculty (and seemingly unavailable to the *amentes* as Aquinas describes them), it is not necessarily true that the *amentes* and *furiosi* are denied participation in rational life. This has to do, more than anything, with Aquinas’ strong conviction that human living and human habituation in virtue is a corporate affair, not reducible, *pace* Reinders, to individual capacity.\textsuperscript{71} Aquinas is very clear, for example, that despite an inability to profess the truths of Christian faith, the *amentes* should be baptized, like children, in the faith of the church (*in fide ecclesiae*).\textsuperscript{72} This means, then, that the

\begin{footnotes}
\item[69] \textit{STh} IIaIIae q. 75 a. 2 \textit{resp.}
\item[70] \textit{STh} IaIIae q. 91 a. 2 \textit{resp.}
\item[72] \textit{STh} IIIa q. 68 a. 12 \textit{resp.} Of note, for the *furiosi*, Aquinas’ instruction is more nuanced. If the person has entered a state of insanity but was previously sane, then their wishes while sane should be respected. Conversely, if a person has intermittent periods of lucidity, or periods in which he/she is capable of understanding the meaning of the sacrament, then the wishes of the person during these times should be respected. The degree to which this prefigures contemporary practices regarding “advance directives” in health care settings is remarkable.

It is true, and in my view regrettable, that Aquinas denies the eucharist to the baptized *amentes* who have never been able to demonstrate devotion to the sacrament (\textit{STh} IIIa q. 32 a. 3), but it is important
amentes, despite having little or no individual exercise of the rational function, are not only counted fully human but, much more, are justified by God’s grace and are incorporated in Christ as members of Christ’s body, with gifts of sanctifying grace and the infused virtues. These gifts are imparted – in the case of children and therefore, by extension, in the case of the amentes – not as act but as habit, so that the baptized amentes can be said to possess the supernatural habit of faith even if they do not display its act. Aquinas specifically states, for example, that the baptized amens has the habit of wisdom (sapientia) but not its act. Furthermore, intellectually limited persons (idiota) who, in prayer, can attend to God but cannot understand either the words spoken or their sense, are in fact doing that which is most necessary in prayer.

It is unlikely that any of these texts will fully allay the concerns of Reinders and the theologians of disability that Aquinas’ narration of reason and will as the locus of the imago dei leads to the unintentional ontological marginalization of the amentes and furiosi. This is perhaps appropriate; the undeniable fact that some voices in the Thomistic tradition have equated reason too closely with discursive rationality and that the intellectually disabled have been marginalized should alert contemporary Thomists that this is a permanent danger of Thomistic interpretation. But it is not, in my view,
the best or the most complete interpretation. Like every other human, the *amentes* and *furiosi* are, for Thomas, granted a rational soul; like every other baptized Christian, they are justified *ad extra* by the sacramental grace of baptism and gifted with the infused habits of the theological virtues. Because they do not have proper use of the rational faculty due to bodily contingency, their behavior, when vicious, is not to be counted as sin. But Aquinas does not advocate mere tolerance for the *amentes* and *furiosi*: he calls, rather, for a people so habituated in charity that they are formed to see in the *amentes* not only the gift of a rational soul but, indeed, the infused habit of wisdom.78

8.2.2 Persons of Limited Discursive Capacity: Sacramentally-Assisted Moral Agency

The *amentes* and *furiosi*, however, are not the only humans in whom bodily contingency provides limiting conditions on the exercise of the intellectual faculty. For Aquinas the body in its present state sets intrinsic parameters and limits on human intellectual function, which is to say that for Aquinas the class of humans so limited comprises, to some extent, everyone. Human intellectual fallibility is built into the very structure of Aquinas’ theology, as when he laments in the very first question of the *Summa theologiae* that truths about God “such as reason could discover, would only be

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78 Such an account does not, of course, demand that this habit be actualized. Viewing the *amentes* as those who bear the infused habit of wisdom, rather, entails a commitment to see the *amentes* through the perspective of charity, viewing the *amentes* in the light of God’s love and gifts to them. Thomas’ affirmation that the *amentes* bear the habit of wisdom also has Christological implications, since for Thomas the possession and exercise of *sapientia* is always at the same time a participation in Christ who is *sapientia genita*, Wisdom begotten. “Hence by participating in the gift of wisdom, man attains to the sonship of God [*Et ideo percipiendo donum sapientiae, ad Dei filiationem homo pertingit*];” *STh* IIaIIae q. 45 a. 6 resp.
known by a few, and that after a long time, and with the admixture of many errors.”

Some persons, that is, would never be able to attain sufficient intellectual exercise so as to discover these truths; and even those who attain this, who through a combination of intellectual giftedness and habituation into the intellectual virtues acquire this natural knowledge, would only do so in an arduous, error-prone, and fragmentary way. This is the price that humans pay for being corporeal substances. The angels, who Aquinas describes in instructive contrast to humans, do not have these limitations; although angels, as created beings, cannot know God by God’s essence, they can know God through their own natural principles. Furthermore, the angels do not need discursive reason, which moves from things better known to things less known; they can, instead, instantly grasp the nature of things and are therefore properly called intellectual beings (intellectuales). Humans, on the other hand, depend not only on discursive rationality but also on sense-perception to attain intellectual knowledge.

Aquinas’ contrasting descriptions of human and angelic cognition make clear that some limitation of intellectual function is the normal, not the exceptional, state of human thinking and willing; the amentes and furiosi differ from other humans only in the degree to which the exercise of the rational faculty is hindered and are therefore not ontologically or categorically different from anyone else. This limitedness of human thinking then leads directly and inexorably to a limitedness of human willing, as the will (the intellectual appetite) pursues that which the (limited) intellectual faculty presents to

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79 STh Ia q. 1 a. 1 resp. per rationem investigata, a paucis, et per longum tempus, et cum admixtione multorum errorum, homini proveniret
80 STh Ia q. 56 a. 3 resp.
81 STh Ia q. 58 a. 3 resp.
82 STh Ia q. 79 a. 8 resp.
it as worthy of pursuit. This cognitive-volitional apparatus, never infallible even in the state of original righteousness, is made much more faulty in the context of original sin (peccatum originale), which Aquinas describes as an inordinate habitual disposition of the soul.\footnote{STh IaIIae q. 82 a. 1 resp.} Original sin renders it impossible for a person consistently to know truth and to do good without the assistance of grace,\footnote{STh IaIIae q. 109 a. 8 resp.} specifically by making the human more liable to turn inordinately to lesser, mutable goods, an inordinateness which Aquinas, following Augustine, describes as concupiscence (concupiscentia).\footnote{STh IaIIae q. 82 a. 3 resp.} Aquinas’ description of original sin by analogical contrast with bodily sickness (just as sickness is the privation of health, so also original sin is the privation of original righteousness)\footnote{STh IaIIae q. 82 a. 1 ad2.} and his insistence that original sin resides properly in the soul and not in the flesh\footnote{STh IaIIae q. 83 a. 1.} should not obscure the fact that for Aquinas the faculties which are operationally disordered by original sin are, in the case of the sensitive appetites, embodied faculties which require the body for their proper function.\footnote{STh IaIIae q. 83 a. 4 resp.; q. 83 a. 3. Of note, in IaIIae q. 83 a. 3, Aquinas states that because original righteousness was a rectitude of the will, so also original sin must be understood first to regard the [noncorporeal] will, in which is seated the “first inclination to commit a sin.” But this is a logical, not a psychological, distinction: since the infection of the will quickly affects the sensitive appetites (q. 83 a. 4), the function of the human agent wounded by original sin is an indissociably embodied function.} Aquinas’ assessment of human agency would therefore seem rather bleak: through bodily contingency, which distinguishes humans from angels, human intellective and volitional function is already variable and limited; and what capacity exists is itself weakened considerably by the transmitted disorderliness of original sin.

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\begin{itemize}
\item \footnote{STh IaIIae q. 82 a. 1 resp.}
\item \footnote{STh IaIIae q. 109 a. 8 resp.}
\item \footnote{STh IaIIae q. 82 a. 3 resp.}
\item \footnote{STh IaIIae q. 82 a. 1 ad2.}
\item \footnote{STh IaIIae q. 83 a. 1.}
\item \footnote{STh IaIIae q. 82 a. 3 resp.; q. 83 a. 4. Of note, in IaIIae q. 83 a. 3, Aquinas states that because original righteousness was a rectitude of the will, so also original sin must be understood first to regard the [noncorporeal] will, in which is seated the “first inclination to commit a sin.” But this is a logical, not a psychological, distinction: since the infection of the will quickly affects the sensitive appetites (q. 83 a. 4), the function of the human agent wounded by original sin is an indissociably embodied function.}
\end{itemize}
Central to Aquinas’ proclamation of the good news of God, however, is that God, in God’s mercy and grace, meets weakened, embodied humans precisely where humans are. Recognizing the inherent and acquired fallibility of human reason, for example, God has provided the truths of *sacra doctrina* not through human reason but through revelation, in a manner accessible not only to masters of the Sorbonne but also to persons of limited education and limited intellectual capacity. Recognizing that humans are embodied beings who rely on the external senses, God has graciously provided the sacraments in order that, through these material things, the human might be drawn to God; the sacraments are, for Aquinas, the corporeal signs grace whereby God ministers God’s grace to embodied humans.

If woundedness of the will and intellect is the basic state of humanity under the condition of original sin, then what distinguishes the *amentes* and *furiosi* from everyone else? It is not, as we have seen, the presence or absence of a rational soul, since Aquinas unequivocally holds that all human beings are gifted by God with a rational soul during gestation. It is also not the distinction between those who have limited use of the intellectual function and those who do not, since all humans experience some limitation of intellectual function on account of their embodied structure. The difference, for Aquinas, seems to be that unlike the *amentes* and *furiosi*, whose bodily indispositions render it impossible for them to exercise sufficiently free volitional capacity, other humans (by exclusion) retain sufficient intellective and volitional capacity such as to

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90 *STh* IIIa q. 61 a. 1 *resp*.
91 *STh* IIIa q. 61 a. 1 *ad2, ad3*.

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serve as the *principia* of their actions. This does not imply that humans are free moral agents, understood along the lines either of freedom of indifference or of freedom for excellence (since neither apply); it does imply, however, that wounded, fallen humans retain *liberum arbitrium* and so are able to mediate, albeit in a limited way, among competing perceived goods. Because this basic structure of practical reason is intact, their vicious actions can be counted as sin (they are, that is, disordered human actions).

It is important, however, not to overstate this distinction. Conceiving the distinction between the *amentes* and *furiosi* and “normal” wounded human functioning in rigid “either/or” categories, in which a particular human *either* is the principle of his/her action *or* is not, *either* is sinning *or* is not, is bound to reinforce Pelagian assumptions regarding human agency and is particularly unhelpful in theological reflection on mental disorder. It is better, instead, to conceive of human discursive/volitional capacity as occupying a spectrum, with one end (point A, let us call it) occupied by a human with no discursive/volitional capacity and the other (point B) occupied by a human with intellectual/volitional capacity not limited by the conditions of embodiment. But these points are largely, if not entirely, unoccupied: no one occupies point B,92 and only a comparatively very few (those, for example, who are comatose) occupy point A. Everyone else – including most persons with intellectual disability and/or mental disorder and including St. Thomas Aquinas himself – fall somewhere in between. Furthermore,

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92 The only possible exception to this is Christ, but here the answer is highly qualified. Considered according to his human nature, Christ took on human nature without the stain of original sin (*STh* IIIa q. 15 a. 1) and Christ’s will was never diverted from the free exercise of the good. Christ freely chose, however, to assume bodily defects, not only to assume the penalties of the flesh due humans after Adam’s sin but also to show himself truly human and to model a morally exemplary life in the face of such defects (*STh* IIIa q. 14 a. 1 *resp.*).
any attempt to set a rigid and uncontroversial boundary between those who are, and are not, the *principia* of their action is doomed to fail. The “intellectually disabled” are limited, it is true, but almost never to the extent that *liberum arbitrium* is wholly abrogated, and the same is true, in different ways and different degrees, of those with other forms of mental disorder. But those who are not “disabled” are also limited, and to use “disability” as a moral-theological boundary is a circular reification of an essentially social judgment. Furthermore, as we have seen, because for Aquinas *ratio* is a teleological concept which far exceeds “discursivity,” it is impossible to plot humans on the spectrum between point A and point B on the basis of discursive capacity alone. Someone of limited discursive capacity, that is, might display more free exercise of intellect and will than someone of high discursive capacity but deeply bound in various forms of vice (more on this in the next section). Better, rather, to state that *all* humans experience bodily limitation in complex ways.

In the next chapter we will consider how this dimensional, rather than categorical, model of embodied limitation on human agency might inform Christian reflection on the use of somatic technologies. For now, however, it bears repeating that Aquinas understands the sacraments to be a gracious way of God’s meeting limited, embodied humans with embodied signs of grace. The eucharist, for example, is the sacrament of spiritual nourishment, just as baptism is the sacrament of spiritual birth and confirmation is the sacrament of spiritual growth.⁹³ (Baptism, confirmation, and eucharist are, by implication, just as foundational to the spiritual life as the vegetative soul is to embodied

⁹³ *STh* IIIa q. 73 a. 1 *resp.*

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function.) As such, although the eucharist is not to be taken by those in mortal sin (for which baptism and penance are appropriate remedies), it does remedy venial sin and also strengthens the believer against future sins of any sort:

For, first of all, by uniting man with Christ, [the eucharist] strengthens his spiritual life, as spiritual food and spiritual medicine, according to Ps. 103:5, *(That) bread strengthens man’s heart.* Augustine likewise says *(Tract. 26, in Joan.): Approach without fear; it is bread, not poison.* Secondly, inasmuch as it is a sign of Christ’s passion, whereby the devils are conquered, it repels all the assaults of demons. *94*

Because of this nutritive and even medicinal power of the eucharist, Aquinas commends it to all who are prepared to receive it, forbidding complete abstinence from it *95* and, in a break with the common practice of his time, commending its daily reception. *96* And while it is true, as stated above, that he advises against the reception of the eucharist for those who can display no devotion (*devotio*) toward it, he still commends it for those who have limited use of the rational function (*quia habent debilem usum rationis*) – a category which could include most humans, including most who are, in our culture, described as “disabled.” *97*

8.2.3 *Acquired Bodily Transmutations*

The third mode of breakdown of embodied agency, in what turns out not to be a straightforward categorical taxonomy at all but rather a shifting and interlocking web of

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*94* *STh* IIIa q. 79 a. 7 *resp.* Nam primo quidem, per hoc quod Christo coniungit per gratiam, roborat spiritualem vitam hominis, tanquam spiritualis cibus et spiritualis medicina, secundum illud Psalms, *panis cor hominis confirma*. Et Augustinus dicit, super Joan., *securus accede, panis est, non venenum*. Alio modo, inquantum signum est passionis Christi, per quam victi sunt Daemones, repellit enim omnem Daemonum impugnationem.

*95* *STh* IIIa q. 80 a. 11.

*96* *STh* IIIa q. 80 a. 10 *resp.*

*97* *STh* IIIa q. 80 a. 9 *resp.*
possibilities, concerns modes of bodily operation which are the result of “top-down causation,” in which bodily limitations are not solely a result of congenital configuration but are acquired in the context of life-in-the-world. In discussions highly relevant for contemporary discussion about mental disorder, Aquinas describes how inordinate (vicious) action of various sorts inscribes its effects on the physiological structure of the passions, rendering future inordinate action more likely. He gives special attention, in this regard, to excessive drunkenness.

Just as for Aquinas, the passions play an important role in well-functioning human moral agency, they also play an important role in the structure of vice. In his account of bodily pleasure (delectatio), for instance, Aquinas describes three ways that delectatio can in fact hinder the use of reason. The first two are, more or less, “bottom-up” processes in which the body’s processes seem to affect the operation of the practical reason: bodily pleasures can distract the reason by focusing attention on themselves rather than on reason’s proper object, or bodily pleasures can themselves contradict reason. But the third involves not only a “bottom-up” process but, in addition, a kind of “top-down” process, in that bodily pleasure (experienced in the sensitive faculty of the soul) is associated with “a certain alteration in the body” (quaedam transmutatio corporalis) which directly hinders the use of reason, “as may be seen in the case of drunkards, in whom the use of reason is fettered or hindered.”

In another section of the Treatise on Passions Aquinas posits that anger (ira), which causes a “bodily disturbance in the region of the heart, so much as to affect even the outward members,” disrupts the

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98 STh IaIae q. 33 a. 3 resp. sicut patet in vinolentis, qui habent usum rationis ligatum vel impeditum.
sensitive powers on which the effective use of reason depends and therefore hinders the use of reason.\textsuperscript{99} Finally, in a discussion which we briefly encountered in Chapter 6, Aquinas rejects the view that the passion of sorrow (\textit{tristitia}) is not associated with a bodily transmutation and instead affirms that sorrow is a profoundly embodied phenomenon, going so far as to postulate a physiological correlate to it in the terms of the four-humor theory.\textsuperscript{100} Sorrow is a stifling passion which acts contrary to, not in accord with, the vital movements of the body,\textsuperscript{101} and “moreover sorrow too sometimes deprives man of the use of reason: as may be seen in those who through sorrow become a prey to melancholy or [mania].”\textsuperscript{102} We see, then, that Aquinas here is clear that (a) the passions are embodied, that (b) the embodied passions can so obscure the rational function so as to render acts of virtue progressively difficult, and that (c) this embodied limitation of virtue cannot be understood as a solely “bottom-up” biological process only but must, rather, take account of the “aboutness” built into the very structure of the passions.

The fact that the passions inscribe themselves on the body complicates any simple association of moral responsibility with intact practical reason, since for Aquinas humans are still culpable for behavior performed under conditions of compromised agency if the compromising state is itself chosen by a deliberate will. This is illustrated, in its complexity, by Aquinas’ account of drunkenness (\textit{inebrietas}; \textit{STh IaIIae} q. 150).

Drunkenness, he states, may be understood either as the state of intoxication, or as the act

\textsuperscript{99} \textit{STh IaIIae} q. 48 a. 3 \textit{resp.} perturbationem corporalem circa cor, ita ut etiam usque ad exteriora membra derivetur.

\textsuperscript{100} \textit{STh IaIIae} q. 37 a. 4 \textit{resp.}

\textsuperscript{101} \textit{STh IaIIae} q. 37 a. 4 \textit{ad2}.

\textsuperscript{102} \textit{STh IaIIae} q. 37 a. 4 \textit{ad3}. Ipsa etiam tristitia quandoque rationem auffert, sicut patet in his qui propter dolorem in melancholiam vel in maniam incidunt.
which leads one to become intoxicated. The former, he states, is not a sin; the latter is a sin, but only if the inebriated state results from inordinate desire and use of wine (\textit{ex inordinata concupiscentia et usu vini}).\textsuperscript{103} Indeed, drunkenness can even be a mortal sin if a man is well aware that the drink is immoderate and intoxicating, and yet he would rather be drunk than abstain from drink . . . In this way drunkenness is a mortal sin, because then a man willingly and knowingly deprives himself of the use of reason, whereby he performs virtuous deeds and avoids sin, and thus he sins mortally by running the risk of falling into sin.\textsuperscript{104}

It would seem from this part of the discussion that Aquinas is advocating stern and moralistic treatment of the drunkard. For Aquinas, though, things are not so simple, as it is far from clear that one can be confident, in individual cases, that a person “willingly and knowingly deprives [himself/herself] of the use of reason,” that intoxication is intended in itself (\textit{per se intentum}).\textsuperscript{105} (It is at least not clear that this applies to many, if not most, modern-day alcoholics.)\textsuperscript{106} Various circumstances can mitigate culpability for drunkenness, and acts committed in an intoxicated state \textit{not intended per se} are excused from sin.\textsuperscript{107} Drunkenness can “fetter the reason” (\textit{ligat...}
rationem) and render resulting acts less culpable.\textsuperscript{108} It is partly for this reason that Aquinas, following Augustine, recommends compassionate and gentle, rather than severe or harsh, response to those who are habitually inebriated.\textsuperscript{109}

While I will not endeavor here to resolve all of the complexities of Aquinas’ system with regard to a complex vice like drunkenness,\textsuperscript{110} it should be clear from this brief discussion that for Aquinas the body’s relationship to moral agency is marked by bidirectional, rather than unidirectional, influence. The body does, indeed, set certain parameters on moral agency, and these may (or may not) render the agent less culpable for his or her vicious actions, but it is also true that moral actions, and the habits which grow from them, recursively affect the disposition of the body. In the case of virtuous habits, as described above, the body will be rendered more cooperative to the free exercise of intellect and will; but in the case of vicious habits (like excessive pursuit of pleasure, as above) the body undergoes transmutation so as to render future virtuous action less likely. In assigning responsibility and culpability for vicious action, therefore,

\textsuperscript{108}STh IIaIIae q. 150 a. 4 ad3.
\textsuperscript{109}STh IIaIIae q. 150 a. 1 ad4.
\textsuperscript{110}It becomes even more challenging to interpret how Aquinas would understand human culpability with regard to a phenomenon like habitual drunkenness when one considers his discussion of certa malitia, “certain malice” or (more literally but awkwardly) “on-purpose badness.” Certa malitia is a cause of sin which expresses itself directly through the will and not through the intellect (as in sins of ignorance) or the passions (as in sins of passion). As such, it always implies moral culpability. But because humans are naturally disposed to pursue the good, the display of certa malitia demands an account of how the will was led to choose wrongly. Aquinas explains that this often happens as a result of a corrupt disposition (dispositio corrupta) which inclines the person to evil. This, moreover, is “either a habit acquired by custom, or a sickly condition on the part of the body, as in the case of a man who is naturally inclined to certain sins, by reason of some natural corruption in himself” (Talis autem dispositio corrupta vel est aliquis habitus acquisitus ex consuetudine, quae veritutur in naturam, vel est aliqua aegritudinalis habitudo ex parte corporis, sicut aliquis habens quasdam naturales inclinationes ad aliqua peccata, propter corruptionem naturae in ipso.) Aquinas, then, clearly recognizes the possibility of embodied predisposition to vice (one thinks here of modern talk of “genetic risk factors”) but does not necessarily hold that such predisposition renders the moral agent less culpable for his or her actions. STh IaIIae q. 78 a. 3 resp.
Aquinas is forced to consider not only the circumstances of the act in itself (a vicious act which is rendered less culpable on account of the intoxication of the agent) but also the various moral choices which gave rise to these circumstances (for example, the person’s decision to “get drunk”). This makes consideration of responsibility and culpability an exceptionally complex task.

8.3 The Role of “Health” in Aquinas’ Grammar of Moral Agency

In the face of this complexity, it would seem natural to turn to “health” (sanitas) as a conceptual means to differentiate medical failures of flourishing from non-medical failures of flourishing. Some readers may wonder why, in a chapter centrally concerned with Aquinas’ account of the body, I have not made “health” a conceptual centerpiece. This is, after all, a work principally concerned with the proper application of somatic psychiatric technologies, which are perhaps better thought of as medical technologies or therapeutics, and so the proper context for reflection would not be Aquinas’ extended treatments of virtue and vice but, rather, of health and disease or sickness. Forget about moral virtue, one might say; the proper task of medical technology is to restore health, which Aquinas also describes as a virtue, albeit of a different type. Once this is done, the medical arts have done their job and should get out of the way of more properly moral approaches.

Aquinas himself, while never centrally addressing medical practice, seems to share the sense that the medical arts exist to restore the health of the body. While he rarely discusses health and sickness per se, he often uses examples from the medical
theory and practice to further arguments within his moral psychology, and these display a generally uncritical and accepting stance toward the use of medicines. The good of health, he writes, consists in a “certain commensuration of the humors in keeping with an animal’s nature” (quadam commensuratione humorum per convenientiam ad naturam animalis) and sickness (aegritudo) follows from disorder of the humors. Medicine can be said to be the cause of health, and even to be “healthy” (sanum), because it restores this humoral balance. Aquinas generally praises this restorative use of medicine and comments that it is preferable to use medicine to attain perfect health than to attain imperfect health without the use of medicine. Although he condemns occult or demonic rituals for the purpose of restoring health, he praises medicines which produce health “naturally” (naturaliter). And in a passage of considerable relevance for contemporary reflection on psychiatric technology, he argues that “sleep and baths” are effective therapies for sorrow (tristitia), basing his defense on the four-humor theory:

*I answer that*, as stated above, sorrow, by reason of its specific nature, is repugnant to the vital movement of the body; and consequently whatever restores the bodily nature to its due state of vital movement, is opposed to sorrow and assuages it. Moreover such remedies, from the very fact that they bring nature back to its normal state, are causes of pleasure; for this is precisely in what pleasure consists, as stated above. Therefore, since every pleasure assuages sorrow, sorrow is assuaged by such like bodily remedies.

111 *STh IaIIae q. 73 a. 3 resp.*  
112 *STh Ia q. 13 a. 5 resp.*  
113 *STh IaIIae q. 5 a. 5 ad2.*  
114 *STh IaIIae q. 96. a. 3 resp., ad1.*  
115 *STh IaIIae q. 39 a. 5 resp.* Respondeo dicendum quod, sicut supra dictum est, tristitia secundum suam speciem repugnat vitali motioni corporis. Et ideo illa quae reformant naturam corporalem in debitum statum vitalis motionis, repugnant tristitiae, et ipsam mitigant. Per hoc etiam quod huiusmodi remediis reductur natura ad debitum statum, causatur ex his delectatio, hoc enim est quod delectationem facit, ut supra dictum est. Unde, cum omnis delectatio tristitiam mitiget, per huiusmodi remedii corporalia tristitia mitigatur.
This kind of approach would seem to open a wide door for a straightforward Thomistic account of medical and psychiatric technology in which modern medicine is to be deployed for the restoration of health. “Health,” of course, would need to be understood not in the terms of the outmoded four-humor theory but in the terms of contemporary biological and psychological science. Such a Thomistic account might look much like Jerome Wakefield’s “harmful dysfunction” model of mental disorder.116 A distinction of this sort would seem to fit well with Aquinas’ distinction between the natural and the supernatural, with the natural good of the body corresponding to health.

There is some evidence in Aquinas’ discussion of habit in the *Summa theologiae* that Aquinas was indeed attracted to this sort of view. In his most direct discussion of health, Aquinas describes it as a habit which properly disposes the body to respond gracefully to the soul’s inclination to good. But unlike in our own medicalized culture, in which health is a much-sought-after end and has been elevated (by the World Health Organization, for example) to the practical status of *eudaimonia, sanitas* is, for Aquinas, a fairly limited concept, with little role within his moral psychology and with commensurately little space devoted to it in the *Summa theologiae*.117 At first, in his most clear discussion of it in the first two questions of the *Treatise on Habits*, he

117 The World Health Organization famously described health in 1948 as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” It is very important not to conflate this concept with Aquinas’ *sanitas*: it much more closely resembles Aquinas’ *beatitudo*. That an international scientific and public health body would continue to use such an expansive definition in its work speaks much to the way that “health” functions in contemporary culture as a teleological concept, more powerful for being unnamed as such. Of note, in their Catholic analysis of medical ethics, Ashley and O’Rourke (1997) encourage construal of “health” not in a narrow sense of “standard physiological parameters” but rather in a broad sense of “optimal functioning of the human organism to meet biological, psychological, social, and spiritual needs.” Benedict Ashley and Kevin D. O’Rourke, *Health Care Ethics: A Theological Analysis*, 4th ed. (Washington, D.C.: Georgetown University Press, 1997), 22-25.
attributes the status of health as a habit to Aristotle\textsuperscript{118} and then (as noted above) seems to oppose it to the operative habits, such that health names not the disposition of the embodied soul to a particular operation (as would the operative habits such as the moral virtues) but rather the disposition of the body to its form. Health, that is, names the right-ordering of a body capable of doing what bodies are naturally able to do. Such a concept seems to fit perfectly with a Boorse-like or Wakefield-like ethic of medical technology, in which the proper role of medicine is to restore the body to its natural capacities.

The central problem with distinguishing health as a so-called “entitative” habit from the “operative” habits of the moral virtues, in which health is a habit which disposes the body to its form but does not specifically dispose the body-soul to its proper operation, is that Aquinas has no available criterion of evaluation of “health” except the proper operation of the body-soul. This is not an immediately apparent claim, as the four-humor theory on which Aquinas bases his physiological claims, with its talk of “balance” and “commensuration” of the humors, would seem to provide just such a criterion: “health” would seem, on the terms of the four-humor theory, to be that state of the body in which the humors are properly balanced (let us set aside concerns, for the moment, about the validity of the theory and focus only on how Aquinas uses it). But the problem with this, of course, is that neither Aquinas nor the physicians of his time had any way to measure the humors directly, much less to determine whether they were in proper balance, without recourse to the operation of the organism. “Melancholia,” that is, was diagnosed not by a direct measurement of the gallbladder or of any other

\textsuperscript{118} STh IaIIae q. 49 a. 1 \textit{resp.}
particular organ, but by observation of particular clinical operational signs (lethargy, anergia, sadness) which were presumed to correspond with an excess of black bile.

This inability to recognize proper humoral balance without recourse to the operation of the organism, which is exactly mirrored in modern vacuous talk about “chemical imbalance,” means that the distinction between the “entitative” habit of health and the “operative” habits of the moral virtues, though logically coherent, is nearly useless in practice. Aquinas, to his credit, seems to recognize this, and perhaps for this reason sanitas is not a concept which does much work within Aquinas’ theory. Even the aforementioned apparent distinction between entitative and operative habit in which sanitas is an exemplar of an entitative habit is rendered problematic and is undercut by Aquinas’ insistence that even health is ultimately ordered to operation:

Health is said to be a habit, or a habitual disposition, in relation to nature, as stated above. But insofar as nature is a principle of act, it consequently implies a relation to act. Wherefore the Philosopher says (De Hist. Animal. x. 1), that man, or one of his members, is called healthy, when he can perform the operation of a healthy man. And the same applies to other habits.\(^\text{119}\)

If this is the case— if nature is so oriented to act that rightly-disposed nature is a nature rightly disposed to act, such that act (or at least the capacity for act) is the criterion of evaluation for whether nature is indeed rightly disposed— then any theoretical system which attempts to specify “health” (and, perhaps in particular, “mental health”) prior to or independently of the moral virtues, will be bound to fail since the moral virtues are

\(^{119}\) STh IaIIae q. 49 a. 3 ad3. sanitas dicitur habitus, vel habitualis dispositio, in ordine ad naturam, sicut dictum est. Inquantum tamen natura est principium actus, ex consequenti importat ordinem ad actum. Unde philosophus dicit, in X de historia Animal., quod homo dicitur sanus, vel membrum aliquod, quando potest facere operationem sani. Et est simile in aliis.
those habits which enable the performance of virtuous acts with ease and consistency. It
certainly, at least, would not be Thomas’ view.\textsuperscript{120}

8.4 Toward a Recursive Teleological Account of the Body

In the course of this chapter I have argued that Aquinas understands the exercise
of moral virtue as a deeply embodied phenomenon, in which the body is so configured so
as to respond gracefully to the soul’s participation in the life of reason. Any habitual
disposition to breakdown of this harmonious interplay is broadly understood to be vice,
which itself may have the character of sin, of disease/sickness, or of both. Understanding
the relation between disease and sin (and, more broadly, between disease and agency) is
extraordinarily complex in Aquinas. Aquinas considers some cases (primarily the
\textit{amentes} and \textit{furiosi}) in which the exercise of the rational function is so impaired by
bodily indisposition that culpability for vice is partially or wholly abrogated. There is,
however, no clear boundary-marker between these persons and other humans, who are
also limited in various ways by the body and yet still are understood as the \textit{principia} of
their actions and are therefore morally accountable for them. Furthermore, these
boundaries are blurred even more by the complex way in which virtue and vice inscribe
themselves on the body, particularly through the medium of the passions, rendering virtue
and vice more likely or less likely in the future. It turns out, therefore, that one can only

\textsuperscript{120} To be sure, Aquinas does not say here that a man can be called healthy only when he \textit{is} performing the
operation of a healthy man, but rather that he can be called healthy when he \textit{is able to} perform the operation of a healthy man. In other words, one can, on Aquinas’ terms here, be healthy without, at the time,
performing virtuous acts. The point here, however, is that “health” cannot be specified outside of a larger
teleological context of what it looks like to perform virtuous acts.
rarely ascribe a particular inordinate behavior solely to the body: most human behavior, vicious or virtuous, is behavior of the body-soul composite, not reducible to either body or soul alone. Health (sanitas), which appears initially promising as a way to demarcate proper disposition of the body without reference to the operation of the soul, turns out not to be able to provide this demarcation because health itself is only recognized in the context of proper (or, in the case of disease/sickness, improper) operation of the embodied soul.

In the final chapter, we will consider how to integrate these insights into constructive reflection about the place of psychiatric technology within the Christian life. There are, it turns out, no easy ways to demarcate medical from non-medical failures of flourishing, and yet Aquinas’ robust teleological account of the human moral life provides a critically important context within which to frame particular questions about what constitutes bodily health for a particular person. This, correlatively, furthers prudential discernment about the proper applications of medical/psychiatric technology in that particular person. Health is, after all, a recursive concept, and psychiatric diagnosis is therefore, inevitably, a prodigal child of ethics.
O amantissime Pater, 
concede mihi 
dilectum Filium tuum, 
quem nunc velatum in via 
suscipere propono, 
revelata tandem facie 
perpetuo contemplari

O most loving Father, 
give to me 
Your beloved Son, 
Whom now I intend to receive 
in this hidden form 
but hope to contemplate 
face to face for all eternity,

Qui tecum vivit et regnat 
in unitate Spiritus Sancti Deus 
per omni saecula saeculorum.

Who with You lives and reigns 
in the unity of the Holy Spirit, 
world without end.

Amen.

Amen.

--from, St. Thomas Aquinas, “Before Communion”¹

The purpose of this concluding chapter is to draw together the many different discourses and contexts covered in this work so far, and to point the way toward a constructive Christian engagement with psychiatric technology. The proposals offered here are not the first constructive account regarding Christian engagement with psychiatry – my argument will have certain similarities to, as well as differences from, that of Johnson (2007), Brugger (2009), Ashley et al. (2006), and Bringle (1996) – and certainly will leave many questions undeveloped.² I seek, rather, to further the


conversation by providing recommendations which are informed both by the contemporary philosophy-of-psychiatry literature, to which few Christian thinkers have closely attended, and by the philosophy and theology of St. Thomas, in hope that such a framework will enable further constructive exploration.

Let us review, briefly, the ground covered so far in this work. I began by arguing that “biological psychiatry” is an influential and arguably dominant movement within contemporary psychiatry, medicine, and mental health practice, evidenced in part by the widespread and increasingly quotidian acceptance of psychiatric medication (and, to a much lesser extent, other psychiatric technologies such as electroconvulsive therapy and transcranial magnetic stimulation). Surprisingly, however, biological psychiatry – and the use of psychiatric medication more generally – has received relatively little attention within the theological literature or from theologically-informed clinicians. In an effort to account for this absence, I briefly reviewed five leading communities of discourse regarding the intersection of theology with mental health practice: the “pastoral care” movement, the integrationist movement, the “biblical counseling” movement, the “Christian psychology” movement, and the Catholic-oriented movement centered around the work of the Institute for Psychological Sciences. These movements are diverse and disparate, serving different purposes and (especially) different communities, with different and irreconcilable attitudes toward psychology and psychotherapy. Regarding biological psychiatry and psychiatric technology, however, they are more unified than

would often appear, in part because even those movements which are generally skeptical of contemporary clinical psychology (e.g., the biblical counseling movement) often defer to the medical model, such that an illness with biological cause is presumed to be the province of the physician, not the Christian pastor or counselor. Furthermore, the political and historical preoccupation of these communities with psychology and psychotherapy generally makes them less attentive to the somewhat different questions relevant to psychiatry.

In Chapter 2, I argued that despite common misperception, neurobiology and the modern experimental sciences more generally cannot provide comprehensive conceptual ground for psychiatric nosology or the use of psychiatric technology for the simple reason that neurobiology cannot, on its own terms, account for what makes a particular configuration of behavior, thought, and affect a “mental disorder” – a designation which depends for its intelligibility on a wider frame of reference than neurobiology alone is able to provide. Biological psychiatry is therefore always dependent on a nosology which is informed by experimental science but not comprehensively constituted by it. Questions of proper nosology, I argued, are historical and philosophical as well as scientific questions, and any understanding of modern psychiatric nosology (specifically, that embodied in the DSM) demands understanding of all three. After providing a brief historical overview of the development of the DSM tradition, along with an account of philosophical and social critics of various nosological and practical forms, I presented a rough typology of contemporary models of “mental disorder” found in the modern clinical and philosophy-of-psychiatry literature: naturalistic accounts of mental disorder
(e.g., Boorse, Wakefield), values-based accounts of mental disorder (e.g., Fulford, Sadler), and pragmatic accounts of mental disorder (e.g., Brendel, Bolton, Zachar, Ghaemi). All of these models, I argued, are informed by neurobiology, but none are explicable or amenable to evaluation by reference to neurobiology alone.

In Chapters 3 and 4, I turned from historical and philosophical survey to critical engagement with the DSM tradition, using the work of Alasdair MacIntyre as an analytical guide. In Chapter 3, using MacIntyre’s typology of moral philosophies in *Three Rival Versions of Moral Enquiry*, I argued that the DSM tradition cannot be understood in encyclopedic mode without becoming fatally vulnerable to various genealogical critics (e.g., Szasz, Foucault, Laing). Instead, I argued, the DSM should (indeed, must!) be understood as a form of tradition-constituted enquiry, arising from a particular political community (American psychiatry) to serve the practical needs of that community (classification of mental disorders for purposes of coding, research, and clinical practice) and, therefore, reflective of the moral strengths and moral weaknesses of that community. The DSM project is therefore a contingent and historical enterprise, though that does not impugn its validity as a (non-encyclopedic) scientific document: the DSM project is valid, rather, insofar as it is able to withstand the challenges (scientific/empirical challenges, ethical challenges, sociocultural challenges) of other traditioned accounts. In Chapter 4, I extended this argument by holding that psychiatric nosology is irreducibly teleological, insofar as any account of “dysfunction” (upon which judgments of disorder stand) displays some conception, however broad, of what proper function would look like for a particular person in a particular situation. Psychiatric
nosology adequate to the complexity of clinical practice, therefore, requires (a) some conception, whether named or not, of what it means for a particular person to flourish in a particular situation, and (b) some way to distinguish failures of flourishing which are best described within a medical model (e.g., injury or disease) from failures of flourishing which are best described within non-medical models (e.g., ordinary vice). I returned to MacIntyre, this time in _After Virtue_, to suggest that psychiatric nosology is marked by incommensurable disagreement in part because contemporary psychiatry lacks any coherent set of ends, other than the vague and little-articulated end of “mental health,” by which to orient clinical practice.

In Chapter 5, I argued, by way of a close historical and philosophical description of Post-Traumatic Stress Disorder (PTSD), that psychiatric nosology does not simply reflect and classify experience but also constructs it. To receive and to internalize a psychiatric diagnosis, I argued, can be a kind of linguistic conversion in which the whole of one’s experience – past, present, and future – is organized and understood in a new light: not just experience but the experiencing self is changed. _How_ this happens must be understood on a case-by-case basis, as different mental disorder constructs have different histories, and different persons receive and interpret particular constructs in different ways. In the case of PTSD, I argued, a form of experience initially described as a sign of a morally broken war (the U.S. engagement in Vietnam) became, in the hands of the DSM-III Task Force, a mental disorder which inhere in an individual and which lost much of its contextual specificity, with the unfortunate result that the sequelae of
traumatic combat experience have lost much of their moral sense and are increasingly conceived as targets for various forms of technical intervention.

In Chapter 6, I introduced Thomas Aquinas as a helpful conceptual resource for Christians seeking to engage this contested and variable terrain of contemporary psychiatric nosology and psychiatric technology. Aquinas’ thirteenth-century concerns are, I argued, surprisingly resonant with our own, not least because he was as open as any in his day to the claims of empirical science and to new developments within physiology and neurobiology (of which the state of the art was, for him, variants of the four-humor theory). Unlike most modern thinkers, however, Aquinas situates this attentiveness to the empirical within a broader soteriological and teleological context, a context in which all things are created by God and tend to God as their final end and in which human life has the character of a journey. That this is so can be understood partly from natural reason but more fully only in the light of revelation, *sacra doctrina*. For Aquinas, however, this more expansive context neither effaces nor renders irrelevant the truths of natural reason and the conclusions of empirical study: truth is, after all, unified, and human knowledge begins (but does not end) with the senses.

Chapter 7 provided an account of Aquinas’ theological anthropology and moral psychology which was intended to serve several purposes. First, I suggested that Aquinas’ anthropology can provide not only a helpful account of mind and body and of psychiatric explanation but can also provide, unlike many modern accounts, a teleological account of how a particular technological intervention might fit into the larger structure of a well-lived human life. Second, I provided a broad introduction to
Aquinas’ theory while, third, defending his views against misinterpretations by modern theological critics. *Contra* Nancey Murphy and other Christian materialists and non-reductive physicalists, I argued that Aquinas is not a substance dualist and that yet there are for him important metaphysical and epistemological reasons why the intellectual faculty of the soul must not be dependent on a corporeal organ for its proper operation. *Contra* these same writers, I argued that Aquinas does not deny the importance or dignity of the body and that he is not an individualist in the modern liberal senses of that word. Aquinas, that is, offers modern thinkers a teleologically-oriented, non-Cartesian, non-materialist moral psychology which embraces the goodness and importance of the body and which, following Aristotle, understands humans to be social and political creatures.

This all leads, I argued in the next chapter, to Thomas’ engaging account, particularly in the *Summa theologiae*, of the relationship between the body and the moral agency of the person. Aquinas holds that humans by nature have the limited capacity to deliberate on alternative goods and to choose between them – the human is therefore the *principium* of his or her action – but this capacity develops into true freedom only when the human is oriented toward that which is truly good (God). This journey toward (or away from) the good is for Aquinas an embodied journey; the body participates deeply in the person’s habituation in virtue, particularly though not exclusively through the orienting movements of the passions. When the body, for whatever reason, fails to support the vegetative and sensitive powers necessary for the proper exercise of the intellectual faculty, moral agency is commensurately altered, and culpability for vicious action might be qualified or even abrogated entirely. This failure of the body to function
appropriately can be congenital, as in the case of the *amentes*; acquired, as in the case of the habitual misuser of alcohol; or some combination of both. Limitation on discursive capacity as a result of bodily contingency and/or frailty is not, however, limited to those with discrete pathological conditions; it applies in some degree to all humans in this life. Given this propensity of the body to disrupt the human’s participation in virtue, it would seem that a Thomistic ethic of psychiatric technology would understand the role of medical technology as the restoration and promotion of the health (*sanitas*) of the body, but it is unfortunately not so simple; the state of “health” cannot adequately be specified with recourse to empirical science alone, either in Aquinas’ time or in ours, but rather manifests itself in the context of a body which is functioning in an excellent way.

“Health,” therefore, must be described retrospectively, from the perspective of the virtuous operation of the organism, and therefore the pursuit of health is not entirely dissociable in practice from the pursuit of the moral virtues.

It is not a simple matter to translate this account of Aquinas and this reading of the history of psychiatric diagnosis into a straightforward practical account of the use of psychiatric technology. This is the case not only because of the inevitable limitations of my analysis, but also because, as we will explore later in this chapter, there are important reasons why a Christian ethic of psychiatric technology cannot be reduced to an easy-to-remember algorithm or set of rules. At most, a Thomistic account of psychiatric technology can provide certain guidelines and boundaries within which prudential deliberation and decision-making can properly flourish. Even prior to that, however –
prior to any positive account of when, and how, Christians might use psychiatric technology responsibly – it is important to clarify the context within which these questions are asked in the first place. The Niebuhrian point, that the positive question "What am I to do?" must be prefaced by the contextualizing question, "What is going on?," is perhaps nowhere more apt than with regard to the ethics of psychiatric technology.  

This chapter will therefore begin by engaging the context of psychiatric decision-making and only later engage the positive content of the specific decisions to be made, although content and context, as we shall see, are never fully distinguishable in practice. Before asking "should I make use of this technology?," therefore, it is important for me to ask, "What is the context within which I find the use of psychiatric technology intelligible?" Truthful narration, which both for Aquinas and for psychiatric nosology requires teleological narration, is therefore a necessary preamble to prudential discernment. If a more responsible and socioculturally honest narration of context and experience has no place within it for the medical model, specific questions regarding psychiatric technology might fade away.

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3 H. Richard Niebuhr, The Responsible Self: An Essay in Christian Moral Philosophy (New York: Harper & Row, 1963), 60. Of note, in his famous typology of “man-the-maker” (teleology), “man-the-citizen” (deontology), and “man-the-answerer” (ethics of response), Niebuhr classifies Aquinas as a proponent of “man-the-maker.” But this is an odd characterization of Aquinas, for whom the good and the right are never dissociable, and for whom the natural law is the rational creature’s participation of the eternal law (STh IaHae q. 91 a. 2 resp.). In particular, Niebuhr’s affirmation that “for the ethics of responsibility the fitting action, the one that fits into a total interaction as response and as anticipation of further response, is alone conducive to the good and alone is right,” sounds a lot like Aquinas’ description of one who is well-habituated in the virtue of prudentia.
Much of the time, however, reflection on the context of a particular decision regarding the use of technology does not resolve, one way or the other, the appropriateness of medical/technological intervention. In the second section of this chapter, therefore, I will propose three interlocking guidelines for Christian decision-making regarding psychiatric technology. First, I will argue, the use of technology must take account of the participatory character of human life. The human body, that is, is not properly conceived as an object for technological control but rather as the material aspect of an ensouled human individuum who, though existing in herself as first substance, exists contingently and finds herself on a journey toward God, her proper source and final end. In addition, she is a social and political being who necessarily participates in political community; and if she is baptized, she is granted participation in Christ’s life and, therefore, in the divine nature. The habits which enable progress toward the good are collectively referred to by Aquinas as the virtues, and so habituation in virtue provides a way to name the trajectory of the person vis-à-vis the good. Responsible Christian use of psychiatric technology, I will argue, will be aware of this, asking not whether a particular technology will lead to symptom reduction or functional enhancement but, rather, whether the person will, after using the technology, be more or less enabled to pursue a life of virtue. Second, however, I will argue that such discernment must be prudential; as such, judgments about the use of psychiatric technology in particular situations can best be made by those clinicians, patients, and others who are already habituated in the virtue of prudence and who can therefore discern, in a particular situation, the most appropriate course of action. This naturally
raises questions about who is entitled to make these judgments, and what should be done when the parties to such a decision (for example, a doctor and a patient) differ or disagree. I will argue, therefore, that decision-making regarding psychiatric technology must take into account the necessarily political (i.e., communal) character of the virtues and of clinical decision-making.

Readers who have made this long journey with me may be somewhat disappointed, after such a sustained investment of time and effort, to find that the recommendations which I offer in this chapter are largely formal, naming the context and parameters within which discernment regarding psychiatric technology might proceed rather than concretely describing (apart from a few hypothetical case-examples) a sociopolitical alternative to contemporary psychiatric practice. In addition, given my high regard for certain aspects of the medical model, readers may wonder what practical difference my analysis makes for most forms of psychiatric practice. If the person with schizophrenia continues to receive antipsychotics, one might ask, why bother with the arguments of this dissertation?

It is true that many of the practical interventions within clinical psychiatry will not change considerably in the model I propose here. Persons with schizophrenia will likely continue to receive antipsychotics; persons hospitalized for mania will likely continue to receive lithium; persons hospitalized with melancholic depression may well be treated with ECT. Indeed, I would not have it any other way; these interventions are often important and possibly life-saving, and any practical-theological model which discourages or prohibits them tout court would do irreparable and lasting harm.
What differs in this model, however, is the reason why these technologies are applied, and specifically the role of moral and theological consideration within decision-making regarding psychiatric technology. Gone is the assumption, widespread within large swaths of American Christianity, that specification of “mental disorder” is a matter for medical/psychiatric experts to decide, well outside the domain of moral theologians, and that the principal practical-theological task vis-à-vis “mental illness” is to encourage Christians to accept these specifications (e.g., of the DSM) and to create inclusive communities in which these specifications are granted a priori legitimacy. Gone is the assumption that the proper domain of the church, the clergy, and of theology is the (disembodied) “spiritual” and that, correlative, the body is the proper domain of biomedicine. Gone is the related assumption, widespread among Christian mental health clinicians, that distinctively Christian care of Christian patients involves nothing more, in practice, than ancillary addition of “spiritual” content to the more-or-less unchanged structure of the clinical encounter. Gone also is the contrary (and similarly gnostic) assumption, increasingly rare but nonetheless present within American Christian life, that psychiatric technology is always illicit for Christians because it is improper to modify the body for “spiritual” ends. In the place of all of these assumptions is a practical-theological model in which “clinical” decisions regarding psychiatric technology are also and necessarily ethical decisions, and in which these decisions are inextricable, whether one likes it or not, from the domain of moral theology. And while it is undoubtedly true

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4 For a compelling account of the way that Christian commitments have allowed biomedicine to exercise authority over the body, see Gerald P. McKenny, To Relieve the Human Condition: Bioethics, Technology, and the Body (Albany, N.Y.: SUNY Press, 1997), 7-24.
that most persons with mental disorders such as schizophrenia and bipolar disorder would continue to be treated as before, it is also true that the model here would lend specificity to the use of technology in other contexts (e.g., substance dependence) which are much less clear-cut.

As to the concern that my recommendations here are excessively formal, I concede. The truth is that the DSM and contemporary biological psychiatry have so formed our cultural imagination that we do not know – at least, I do not know – what a more philosophically and theologically contextualized practice of psychiatry looks like. What are needed are practices; but practices, MacIntyre reminds us, require traditions; and traditions require communities committed through time to the pursuit of common ends. This work is intended therefore not as a final word regarding Christian engagement with psychiatric technology, but rather as an encouragement to the formation of communities which can describe such engagement in a robustly concrete, rather than a formal, way.

9.1 Narrating Truthfully and Teleologically

The most important component of decision-making, both for contemporary deliberation regarding medical technology and for Thomistic practical reasoning, is specification of the context within which any deliberation regarding means becomes intelligible. For this reason, decision-making regarding psychiatric technology cannot start with the question, “Should I use this technology in this situation?,” but rather, “How am I to understand the situation in which I find myself?” Within psychiatric practice, the
answer to the latter question often determines the former. If a particular set of experiences can be described, according to the categories supplied by the DSM, as a “mental disorder,” then the use of psychiatric technology to “treat” this “disorder” is not only legitimated but even, in some cases, mandated – the only remaining question being which form of technology to employ. If the set of experiences cannot be described within the DSM framework as “mental disorder” – a rarity, given the expansively broad DSM nosology – then the use of medication and other somatic technology is generally taken to be contraindicated. The logic of this deliberation is simple and clear: as discussed in Chapter 5, when the decision is made to interpret particular experience and behavior through the interpretive framework of “mental disorder,” the medical model is generally entailed. Aberrant or deviant behaviors and unwanted, deviant, or painful experiences become “symptoms” and “signs” of illness and disease. Disease and illness is, of course, that which is to be eradicated; and since most mental disorders are defined by the ongoing existence of their “symptoms” and “signs” – the symptom and signs, that is, are the disorder – “treatment” of mental disorder is coterminous with symptom reduction.

Symptom reduction, then, becomes the end toward which particular technological strategies are deployed: if a particular technology is shown to contribute to symptom reduction in a consistently reproducible way, it is said to be “evidence-based” and it is safely enshrined as a legitimate medical treatment. Here Aquinas’ account of practical rationality seems to cohere very nicely with the actual practice of medical decision-making: the intellect determines the end (eradication of disease, symptom reduction) as a good and the will wills this good; the intellect determines that this good end can be
achieved and the will wills this achievement through some means; the intellect
determines the suitable means and the will consents to this proposed solution; the
intellect settles on a particular means for a particular situation and the will selects this
means; the intellect commands the action, and the will follows through. Once it is clear
that a particular experiential-behavioral configuration is “mental disorder,” the end is
implicitly specified; one may not know which treatment to deploy (that requires medical
education of some sort) but one knows that some form of “treatment” is necessary.

Such an account, however, is hardly a Thomistic formulation, because it seeks to
deploy Aquinas’ structure of practical reason outside of the context of his larger
metaphysical and teleological horizon. There is, of course, much within contemporary
traditions of psychiatric nosology, including the DSM, that a person informed by
Thomistic thought could gratefully embrace. A Thomistically-informed thinker, for
example, could embrace with gratitude the long and rich tradition of close observation
and engagement with suffering and troubled persons, extended over generations of
psychiatrists, without which the DSM could not have evolved and of which the DSM
stands as a (controversial) summation. He or she can embrace the increasingly adept and
sophisticated social-scientific methods which are employed to survey the experience of
populations and to differentiate particular behavioral and psychological syndromes from
each other. He or she could also embrace neurobiological investigation and could
celebrate the explosion of recent knowledge regarding the physiology and molecular and
cellular biology of the brain and nervous system. He or she could also, to a point,

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5 StTh IaIIae qq. 12-17; Eleonore Stump, Aquinas (New York: Routledge, 2003), 277-306.
celebrate the discovery and development of pharmacological and somatic treatments for debilitating mental disorders.

What the Thomistically-informed psychological thinker could not celebrate is the default narration of unwanted, adverse, or disvalued experience and behavior as “symptoms” which are then regarded as objects for technological manipulation. A Thomistic view would certainly not reject the language of “symptom” and “treatment” altogether – such narration is appropriate if the medical model is in fact applicable – but would default to this language only when the experience and behavior of the person cannot reasonably be fit into an intelligible moral space. We may remember that for Thomas the human person is not an isolated monad of subjectivity, nor a reductively material being; the human, for Thomas, is a *viator*, journeying from God to God, created in God’s image and, uniquely among the animals, capable with the assistance of grace of conforming his or her life to the divine *ratio*. Both the will (the rational appetite) and the passions (the sensitive appetites) are constituted in a determinative moral space, *necessarily* pursuing the good as it is apprehended and perceived (the problem, of course, being that in the state of sin, this perception is notoriously unreliable). Neither the will nor the passions, as discussed in Chapter 8, can be considered without reference to their intrinsic “aboutness.” Experience and behavior, therefore, is always *about* something; it does not stand alone and cannot be interpreted out of context. “Symptoms,” therefore, are for the Thomist always also “signs” of the person’s experience of his or her orienting moral space.
What this means, practically, is that prior to seeking or assigning a diagnostic label of any sort, a Thomistic thinker would attempt to reconstruct, from the person’s experience, the interpretive world within which that experience is intelligible and only then, in certain cases, pursue a psychopathological description. In order to be concrete, let us return to the (fictional but realistic) cases of Beth Morris⁶ and Rob Dawkins,⁷ described in Chapter 4. Beth Morris, it may be recalled, is a twenty-five year old woman who presented to a psychiatrist requesting a “refill” of an antidepressant medication for ongoing treatment of her “chronic depression.” Although she allowed that her depression had first appeared in the context of a parental divorce and that they seemed to become worse under conditions of stress and that they seemed to become “symptoms” to be controlled with medication. A Thomistically-oriented clinician would not immediately rule out the use of psychiatric medication, but would want to know

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⁶ Repeated from Chapter 4: Beth Morris is a twenty-five year old woman who presents to a psychiatrist for a first visit requesting a “refill” of her antidepressant medication bupropion (trade name Wellbutrin XL), stating that her previous psychiatrist was moving out of state and had referred her for further care. Although she says that she is taking the medication for “chronic depression,” a careful diagnostic interview reveals that she has never had what the DSM would categorize as a major depressive episode; she does, however, meet the criteria for the related category of Dysthymic Disorder (300.4), characterized by at least two years of depressed mood for most of the day, more days than not, along with (in her case) low energy and low self-esteem. She says that these symptoms date at least to the divorce of her parents when she was a sophomore in high school but seem to remit partially when she takes bupropion, which she was first prescribed six years prior by a student health physician at her university when she had presented with complaint of feeling depressed and stressed after a relationship ended and her coursework seemed overwhelming. She says that bupropion “helps keep me energetic” and that she also likes it because it helps her control her weight.

⁷ Rob Dawkins is a twenty-one-year-old graduate student in neurobiology brought to a psychiatric emergency service by his very worried father, who drove five hours to pick him up after a roommate called to report that Rob was “not right.” Rob is irritated and indignant at being confined in a locked setting in the emergency department and says, quickly and repeatedly, that he is fine, that everything is fine, that he is “better and more productive than I’ve ever been,” and needs to be discharged so that he can go home to work on a novel which he started writing the week before. His father says that the roommate reports that Rob has not slept in 3–4 nights and has acted “like a tornado” for over a week. Rob’s father says that Rob, who loves science but had never previously shown much interest in the literary arts, had decided to write “a great novel” and, in preparation, had mail-ordered a large number of novels, which have started to arrive in large packages at his apartment. Rob’s father is worried in part because Rob’s mother, from whom his father is now divorced, has been in longstanding treatment for bipolar disorder.
much more about the sustaining context of her affective experience, encouraging her to narrate beyond “symptoms” to the interpretive world within which symptoms become manifest. Thomas’ account of the passions might even be helpful in guiding this reconstruction. Let us hypothesize, for example – though this would likely be far too simplistic – that the dominant passion that Beth experiences is tristitia (sorrow), the wilting recoil of the irascible faculty to the sustained presence of a known evil. What, we might wonder, is this evil? What is she recoiling from? Is she recoiling from an evil which is, to external observers, present – and if so, might there in fact be alternatives to counteracting this evil? Or is her perception of a continuously present evil in fact a misinterpretation – and if so, can she display the flexibility to challenge her interpretations? Conversely and correlative, since Aquinas asserts that there is no passion of the soul which does not presuppose love of some kind, one might ask what it is that Beth loves, and how these orienting loves guide the way that she interacts with others in her interpersonal world. We do not have enough information to answer any of these questions, but the point is that the specific answers will do much to determine whether the medical is, in her case, the most helpful grammar for her self-narration. If her experience and behavior can be understood as sign of a deeper valuational structure, the use of psychiatric technology might (or might not) still be appropriate, but the need to narrate this experience in biomedical terms might be quite unnecessary.

The experience and behavior of Rob Dawkins, the twenty-one year old graduate student brought to an ED by his father after several sleepless, euphoric days and nights,  

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8 StTh IaIIae q. 36.
9 StTh IaIIae q. 27 a. 4 resp.
could also be subjected to a Thomistic analysis. Rob is described as being angry at his confinement in the ED, but his dominant passion, a euphoric self-assertion, does not fit well into Aquinas’ structure of the passions. It has some resonance, to be sure, with *concupiscentia*, desire, with regard to the novel he has started to write; and yet this desire is notably disproportionate given the fact that he cared little about novel-writing before the onset of his euphoria. There is also love (*amor*) and delight (*delectatio*); and yet Rob is apparently not content to rest in the presence of any attained object; he continues to press, stretch for . . . what? It seems likely, given the brief description of Rob’s presentation in the ED, that it would be difficult to construct a coherent scheme of loves and desires, faithful to the way that Rob has established himself as a self across time, within which Rob’s present experience and behavior could be rendered intelligible. The Thomistic subordination of the passions to the prompting of the intellect, such that the passions stand as signs of various volitional and intellective valuations, seems to be reversed: Rob’s passions seem to be operating disproportionately to any discernible context, and to be driving his interpretations rather than *vice versa*. Because of this – and even more so because of the experience of his mother – the use of the grammar of “mental disorder” and “symptoms” to describe Rob’s situation seems, on Thomistic grounds, to be quite appropriate.

One could certainly argue that the kind of contextualization which I am here associating with the thought of Aquinas is in fact nothing new, but is what good mental health clinicians do already, is consistent with major psychotherapeutic theories such as cognitive therapy, and is already mandated in many of the *DSM* diagnostic constructs (as,
for example, when Generalized Anxiety Disorder is stipulated in *DSM-IV-TR* as “excessive anxiety and worry”). If this is the case, then Aquinas would no doubt be pleased; because all truth is unified, the Thomistic psychological thinker can celebrate good diagnostic practice in every form in which it appears. But it is simply the case that this kind of contextual and teleological thinking is *not* the universal norm within contemporary mental health practice, and particularly with regard to biological models of psychiatry. This is in part because the *DSM*, as discussed in Chapter 4, provides no adequate basis for making these kinds of teleological judgments. It is easy, that is, to observe that a patient is in distress, or is acting in a way contrary to established social norms; but to judge that a person is acting and experiencing in such a way contrary to his or her proper good as a human and, furthermore, that the will and/or the passions have lost their orienting “aboutness,” requires judgments about the nature of proper human function which do not cohere easily with the liberal presuppositions of contemporary mental health practice, however essential they might be for day-to-day clinical work. What Aquinas provides is a teleological context of human flourishing within which to make these sorts of judgments intelligible.

All of this leads to some very pragmatic and concrete implications for the Christian mental health clinician, or for the Christian wondering whether a particular psychiatric technology should be used in a particular situation (see Figure 1 in Appendix). First, before even asking, “Is this technology (e.g., medication) appropriate?,” one needs to *clarify the context* by asking, (1) “What is the moral and

practical context within which this person finds himself/herself/myself?” Second, one ought to address one’s teleological assumptions by considering, and perhaps even by formulating, the range of affective and behavioral responses commensurate with virtue in the person’s particular situation. One might ask, for example, (2) “What range of experience and behavior do I understand to be commensurate with this particular moral context?” Third, having addressed (or at least having acknowledged the necessity of) one’s teleological commitments, one must make a judgment which displays an answer to the question, (3) “Is the experience and behavior of the prospective ‘patient’ consistent with virtue in this particular context?” If the answer to this question (regardless of whether the question is consciously named) is “yes” – if the emotional, cognitive, and behavioral response of the person in a particular situation is already a virtuous response – then the use of psychiatric technology would be appropriate only in a “palliative” sense – i.e., to alleviate extreme and morally unprofitable forms of suffering. If, on the other hand, the third question is answered negatively – if the experience and behavior of the person is not consistent with virtue or human flourishing in a particular situation – then, as discussed in Chapter 4, a further demarcation is needed, between medical failure of flourishing and non-medical failure of flourishing. As previously discussed, this is a notoriously difficult distinction to make, ripe with the possibility of error, so much so that the DSM, in the interest of diagnostic reliability, largely ignores it except in clear-cut cases of social deviance. But it is a crucially important distinction lest all failures of

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11 This is, of course, a value-laden task which carries intrinsic risk that the clinician, for example, will use the power-imbalance of the clinician-patient relationship to foist contestable teleological assumptions onto a person. We will discuss this risk later in the chapter. For now, however, it must be said that this is nothing new: it is a risk, as described in Chapter 4, which already pertains to every psychiatric clinical encounter, and patients are most vulnerable when, as is usually the case, this risk remains unnamed.
flourishing be rendered subject to medical and technological control. Two guiding questions, neither of them foolproof but both of them powerful and necessary, can help clinicians to judge whether failures of flourishing in a particular context are properly understood according to the medical model. The first of these questions is one of *intelligibility in context*: (4a) “Does this particular configuration of experience and behavior make sense as ordinary vice in this specific context, or do I find it unintelligible as such?” There is the possibility of error either way: the fact that a particular contextual response is consistent with ordinary vice does not exclude the possibility of a medical disorder (one thinks, for example, of hypothyroidism contributing to *acedia*), and the fact that a response is unintelligible to the one who judges may reflect more on the limitations of the judge than on the person judged (ignorance, for example, of culturally-sanctioned responses to particular forms of loss). However, the answer can still go a long way: a failure of flourishing which does not make sense within a specific context as ordinary vice is more likely, and conversely a failure of flourishing easily understood as ordinary vice is less likely, to be properly conceived in the language of the medical.  

The second question which can help clinicians and others demarcate medical from non-medical failures of flourishing relates to what is already known about particular medical risks: (4b) “Are there specific reasons to think that medical/biological factors are contributing to this failure of flourishing?” If, for example, one has multiple first- and second-degree

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12 This, of course, raises a set of thorny questions about how one defines “ordinary vice.” I do not seek to provide a precise definition here. Rather, by “ordinary vice” I refer to configurations of experience and behavior which, though not conducive to human flourishing, make sense to observers who have their own moral experience of the world without recourse to psychopathological concepts. Cheating on one’s taxes and hiding it from the IRS is ordinary vice; not paying one’s taxes and then writing scores of angry, disjointed, threatening letters to the IRS is not.
relatives with schizophrenia, or if one is brain-injured, or if one is taking corticosteroids or other medications with significant neuropsychiatric side-effects, then this would increase the chance that truthful description will include the medical. It is here, more than ever, that fluency in the latest scientific developments within medicine and psychiatry, together with competency in neurobiology, becomes crucial on the part of the one who is making the judgment.

This admittedly complex algorithm for the clarification of the context of decisions regarding psychiatric technology is useful in several ways. First, it provides an important context for psychiatric decision-making which does not rely on the DSM tradition as the sole means for determining what kind of “mental disorder” is present, though it may make profitable use of the clinical and scientific knowledge embedded within the DSM. Second, it makes clear that teleological fittingness and (secondarily) the presence of excessive suffering, rather than the presence or absence of neuropathology, is the primary criterion of judgment regarding whether a particular configuration of experience and behavior is to be counted as “mental disorder.” Third, it provides a means for distinguishing (in a way that is not foolproof, but helpful and necessary nonetheless) between various uses of the concept of “mental disorder,” each of which give rise to different implications regarding the use of technology. At least four distinct (though sometimes overlapping, and certainly non-exclusive) concepts of mental disorder emerge

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13 Although debates about the appropriate limits of psychiatry have traditionally used the term “mental disorder” to demarcate the medical from the non-medical, I will avoid this approach in the constructive analysis proposed here. “Mental disorder” has little explicit meaning other than that something is wrong with the mental life; it does not specify anything about the source or root of that wrong. It is therefore less helpful to ask whether mental disorder is present, than to ask what kind of mental disorder is present. Not all conceptions of mental disorder, as we will see, lay equal claim to the legitimacy of psychiatric technology.
from this form of analysis (see Figure 1, Appendix). First, “mental disorder” can be applied to configurations of experience and behavior which do not intelligibly within the moral and social context in which they are situated; let us call this Mental Disorder₁ (MD₁). Examples of Mental Disorder₁ might include a person with schizophrenia experiencing a first-episode psychosis, a person experiencing a manic episode (e.g., Rob Dawkins), or a person who is so profoundly depressed as to have lost the capacity for reflective emotional interaction with good things in the world.¹⁴

Second, “mental disorder” can be applied to configurations of experience and behavior which are a result, in part or in whole, to known medical or neurophysiological lesions; let us call this Mental Disorder₂. Mental Disorder₂ is by no means exclusive of Mental Disorder₁ – a person might display unintelligible response (MD₁) and this response may be due to a known lesion (MD₂) – but it fits even more cleanly into the medical model. Examples of Mental Disorder₂ might include mood and cognitive disturbance after multiple small strokes (e.g., vascular dementia); progressive cognitive, behavioral, and neurological deterioration due to Huntington’s disease; and steroid-induced psychosis. Third – and significantly more controversially – “mental disorder” can be applied to deeply entrenched forms of ordinary vice which do not fit the categories of MD₁ or MD₂. Examples of Mental Disorder₃ might include certain forms of what the DSM refers to as personality disorder (e.g., narcissistic personality disorder), certain of the addictions (e.g.,

¹⁴ In arguing that MD₁ is characterized by unintelligible contextual response, I do not argue that the experience of persons with MD₁, e.g. schizophrenia, is wholly irrational or unintelligible. Quite the opposite: in a Thomistic model, such experience should be often, if not always, intelligible if one understands the perceptual context within which the person interprets the nature of the good. The problem, though, is that the context within which the person’s experience and behavior are intelligible is a different context from that shared by others – and in that respect, the experience and behavior is unintelligible within the socially shared context.
certain forms of alcoholism, or compulsive gambling), and certain forms of mood and anxiety disorder (e.g., certain cases of generalized anxiety disorder). Finally, and most controversially of all, “mental disorder” might be used to describe a configuration of experience and behavior which may not be inconsistent with virtuous action, but within which suffering is intolerable and profitless (here referred to as Mental Disorder); an example of this might include the torments associated with certain manifestations of post-traumatic stress disorder or even with bereavement.

All of the deliberation described in this section occurs, on a conceptual level, before the crucial clinical question, “What uses of psychiatric technology are appropriate in this situation?” can be answered. Furthermore, none of the various conceptions of “mental disorder” described above entail that the use of psychiatric technology is appropriate. For this, an additional set of considerations, focused less on context than on application, is necessary.

9.2 Thomistic Guidelines for the Use of Psychiatric Technology

We turn now to the practical question toward which this entire work has been directed: when is it appropriate for Christians to use psychiatric technology? As alluded to earlier, I will here propose three guidelines, influenced by St. Thomas’ work as described in chapters 6, 7, and 8, for the Christian application of psychiatric technology. Although they are interlocking and interdependent, and therefore could be considered in

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15 In arguing that persons with MD exhibit ordinary vice, I do not argue that such conditions cannot be biologically enabled, at least in part. They can be, and are, as are all forms of human experience and behavior. They are distinguished from MD, however, in that there is no identifiable biological cause which can be specified to exist independently of the condition itself.
any order, I will describe them in the order that is most clear with respect to on-the-ground psychiatric decision-making. We will consider first the participatory ends of the person of which such decision must take account, then the prudential way in which such decisions must be made, and finally the political context of both participatory and prudential discernment.

9.2.1 Guideline 1: Psychiatric technology may be used when it helps, and does not hinder, participation in the good.

For Aquinas, as discussed in chapters 7 and 8, the human is a “first substance” in that he/she does not need any other natural thing in which to inhere, and yet even the human soul, a subsistent form which (considered per se) comes to be at once and does not move from potentiality to act, is constituted in participation:

Everything participated is compared to the participator as its act. But whatever created form be supposed to subsist per se, must have existence by participation; for even life, or anything of that sort, is a participator of existence, as Dionysius says (Div. Nom. v). Now participated existence is limited by the capacity of the participator; so that God alone, Who is His own existence, is pure act and infinite. But in intellectual substances there is composition of actuality and potentiality, not, indeed, of matter and form, but of form and participated existence. Wherefore some say that they are composed of that whereby they are and that which they are; for existence itself is that by which a thing is.

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17 *STh Ia* q. 75 a. 5 ad3.
18 *STh Ia* q. 75 a. 5 ad4. Ad quartum dicendum quod omne participatum comparatur ad participans ut actus eius. Quaecumque autem forma creata per se subsistens ponatur, oportet quod participet esse, quia etiam ipsa vita, vel quidquid sic dicetur, participat ipsum esse, ut dicit Dionysius, V cap. de Div. Nom. Esse autem participatum finitur ad capacitatem participantis. Unde solus Deus, qui est ipsum suum esse, est actus purus et infinitus. In substantiis vero intellectualibus est compositio ex actu et potentia; non quidem ex materia et forma, sed ex forma et esse participato. Unde a quibusdam dicuntur componi ex quo est et quod est, ipsum enim esse est quo aliquid est.
In this rather dense metaphysical account, Aquinas affirms, as he does throughout the *Summa theologiae* and his other works, that the existence of the created being is always and necessarily a participated existence (*esse participatum*). God, whose existence alone is necessary, is the source and final end of all creatures; correlative, just as the existence of created things is a participated existence, so also the goodness of created things is a participated goodness.19 Although all created things tend toward the perfection of their natures, only humans are granted the intellective, rational, and volitional capacity to know universal truths and to desire the universal good. Because of this, so to speak, humans can become participants in their own participation in goodness – and the habits which enable this participation are, for Aquinas, the intellectual, moral, and theological virtues. To become habituated in virtue is, then, to find oneself drawn further into participation of the good which is one’s final end. Furthermore, Aquinas holds that this participation in good, as enabled by supernatural grace which surpasses the natural capacities of the creature, is participation in God’s divine goodness.20 This grace-assisted participation in God’s goodness, actualized in the theological virtues, is participation in the Godhead,21 a participation made possible by the incarnation of the Word of God.22 Although these various participatory contexts are conceptually distinguishable according to their relationship to the natural capacity of the human creature, they become, for the baptized Christian, aspects of one integrated whole: because goodness is one, all virtues enable progress toward the same good because God

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19 *STh* IaIIae q. 2 a. 8 *resp.*
20 *STh* IaIIae q. 110 a. 1 *resp.*
21 *STh* IaIIae q. 62 a. 1 *resp.*
22 *STh* IIIa q. 1 a. 2 *resp.*
is their proper end; it is for this reason that Aquinas holds that charity, the gracious love of God by which God enables the creature to love God in return, is the form of all of the virtues.  

Psychiatric technology has the capacity either to help or to hinder the embodied person’s habituation in virtue as this is interpreted in particular contexts, and therefore to affect the trajectory of his or her participation in the good. This is not, of course, to be overstated: contra the rhetoric of many critics of modern psychiatry, most psychiatric medications and other technologies do not radically alter one’s personality or basic moral orientation to the world. They can, however, have subtle and yet far-reaching effects, for good or for ill. A few examples, both from the modern clinical context and from Aquinas’ treatment of the passions, will make this clear.

If the vegetative and sensitive faculties of the soul – what contemporary psychology would understand as basic physiology, sensation, perception, generation and regulation of emotion, accurate appraisal of danger, and episodic memory – are functioning in a way to reliably reflect the context in which the person finds him/herself, psychiatric technology has the potential to disrupt the orienting signs on which healthy moral functioning depends. Let us imagine, as an example, the case of a man who is deeply addicted to internet pornography and who spends much of each night with eyes glued to a computer monitor. Let us imagine that he feels not only tired (from lack of sleep) but ashamed and frustrated at the gap he experiences between the idealized sexual images of his fantasy and his very real and un-idealized relationship with his aging and

23 STh IIaIIae q. 23 a. 8 resp.
increasingly angry wife. Let us then imagine that he presents to a biologically-oriented psychiatrist stating that he has been feeling “depressed,” with little interest in things that previously brought him pleasure, irritability, depressed mood, poor energy, and poor appetite, and even thoughts of suicide, without divulging anything about his sexual thoughts and behaviors. If this psychiatrist is inclined to disregard context in favor of DSM formulations, or is simply hurried, he or she is likely to interpret this man’s experience as an open-and-shut case of major depression and to prescribe an antidepressant medication which will (predictably, albeit not universally) subtly change the way that his body generates anxiety signals and structures mood-experience, so that in several weeks he will (on average) feel slightly less angry, less frustrated, less depressed, and possibly less sexually arousable. But what relationship will this have to his habituation in virtue? In Thomistic perspective, the passions function for a reason; they stand as signs of the relationship of a personal subject to the objects which constitute his or her world. The person described here moves toward idealized and unattainable sexual objects (technologically-modified and economically-commoditized persons) which awaken intense desire and yet never bring contented fulfillment; furthermore, movement toward these objects demands movement away from other objective goods in his life (particularly his flesh-and-blood spouse). The persistent failure of pornography to bring lasting contentment, his internal conflict about engaging in activities which he knows not to be health-producing, and his increasing distance from other life goods leave him feeling ashamed, discontent, adrift – and he narrates this, using the available “symptom pool” of modern culture, as “depression.” But the Thomistically-oriented psychiatrist
would not want to technologically modify these feelings; instead, he or she would want
the person to attend to them very closely, to discern their meaning, and to use them as
guides to moral re-orientation toward goods which can more fully satisfy.

A variation of this theme, however, might lead to a different conclusion regarding
the appropriateness of psychiatric technology. Let us imagine that in the context of his
relationship with a wise psychiatrist, this same man elects not to take any psychiatric
medication and becomes fully aware of the moral meanings of his experience. He begins
to make sincere efforts, insofar as decisions are within his power, to change and to reform
his patterns of thought and behavior. He restricts his computer time and discontinues his
internet subscription. He fully discloses his activities to his wife, seeks (and obtains) her
forgiveness, and engages with her in marital therapy to address longstanding problems in
their relationship. He confesses his consumption of pornography as sin and becomes an
active participant in church activities. He begins work with a spiritual director and with
an individual therapist. He does all of this, and yet he remains deeply tormented by
longstanding, deeply-habituated patterns of sexual desire. He finds it difficult to go to
church because he finds himself “sizing up” and mentally undressing the bodies of the
women around him. His dreams are filled with distressing (and yet, even more
distressingly, satisfying) remembrances of pornographic scenes. Remembering a
discussion of antidepressant side-effects from an earlier conversation, he asks his
psychiatrist if he might start a selective serotonin reuptake inhibitor, specifically
paroxetine (Paxil), as he understands that up to half of men who take this drug experience
lower sexual desire in addition to reduction of anxiety. His psychiatrist, after warning
that this is an “off-label” use of paroxetine, agrees to prescribe the medication. He returns a month later feeling less anxious overall, and with far fewer unwanted sexual thoughts and feelings. Both he and his wife are pleased with this.

These two cases involve the same psychiatrist, the same patient, and (possibly) the same drug, but the circumstances of each case are different and the object of the act of prescribing Paxil differs substantially. In the first case, the object of the act of prescribing is to blunt the distressing affective signals which, if attended to, could help to reorient the patient toward virtue; in this case, the use of psychiatric technology would have been inappropriate. In the second case, however, the object of the act of prescribing Paxil is to blunt his not-yet-reconfigured sexual appetite in order to support his ability to remain committed to virtuous action without lapsing again into the use of pornography or other inappropriate sexual activity. Such a medication is not equivalent to a contraceptive, as it does not separate his procreative capacity from sexual intercourse, nor does it directly alter his reproductive function or capacity. Such a use is “off-label” by medical standards but would, in this moral account, be appropriate.

It is important to note that each of these cases cited above correspond to Mental Disorder; in the taxonomy provided earlier in this chapter, that of deeply habituated vice. It is not clear that either this patient’s addiction to pornography nor his reactive depressive and anxiety symptoms are necessarily medical in nature, but this has little relevance for whether psychiatric technology is appropriate. Nor is the DSM a reliable standard: the DSM would clearly recognize the first case above as “mental disorder” (Major Depressive Episode and/or Dysthymia) but would likely not so recognize the
second case. Rather, the decision as to whether or not psychiatric technology is appropriate must be a moral decision as to whether or not the use of technology is likely to aid or hinder the person’s participation in virtue.\textsuperscript{24}

The decision to employ psychiatric technology in the treatment of Mental Disorder\textsubscript{1} (unintelligible contextual response) and Mental Disorder\textsubscript{2} (experience/behavior resulting from extrinsic physiological lesion) may seem much more straightforward – and, to a certain extent, it is – but the same basic considerations apply to these as to Mental Disorder\textsubscript{3}. The use of psychiatric technology for Mental Disorder\textsubscript{1} seems intuitively obvious, but this is specifically because the pursuit of virtue is possible only when the vegetative and sensitive faculties of the soul are sufficiently functional so as to enable such a pursuit. The primary reason for treating schizophrenia with antipsychotic medication, for example, is to enable the affected person to regain (or maintain) sufficient rational capacity so as to be able to order his or her action toward particular chosen ends. But there may be some cases where the use of technology for Mental Disorder\textsubscript{1} is not appropriate, principally when the unintelligibility of response is due to ignorance or malice on the part of the clinician (one thinks, for example, of the institutionalization of Soviet dissidents). Similarly, the use of technology for Mental Disorder\textsubscript{2} is subject to much the same set of considerations. While it is reasonable to use technology to correct any known, correctable biological lesion (e.g., administration of thyroid hormone supplementation for those with confirmed hypothyroidism), it is important to remember

\textsuperscript{24} I confess to some reservation about endorsing this use of technology because I do not want to open the door to a “slippery slope” in which any technology which might enhance a person’s participation in virtue is thereby rendered licit. But I am reminded, as we will discuss later in this chapter, that the virtue of prudencia is necessary specifically because of this danger.
that most (if not all) psychiatric technologies are used to control symptoms but do not correct lesions or provide permanent cures. In this case, the presence of a physiological lesion is formally irrelevant to whether symptom-control technologies should be used, however much it might legitimate attempts to cure the lesion: psychiatric technology should be used insofar as it helps, and does not hinder, the embodied person’s participation in virtue.

These considerations find some support in Thomas’ discussions of pain (dolor) and sorrow (tristitia) in his consideration of the passions, as briefly discussed in Chapter 8. Aquinas is clear that inward pain (sorrow) can be more acute and more aversive than outward pain, not only because inward pain is repugnant to the appetite directly whereas outward pain is repugnant to the appetite only because it is repugnant to the body, but also because inward pain is less specific and more universal: “Sadness of the heart,” he quotes ben Sirach, “is every wound.” For these reasons, Aquinas writes, inward pain is even less desirable than outward pain, evidenced by the fact that individuals will submit themselves to outward pain in order to avoid inward pain, and may even thereby find some pleasure in the outward pain.

Inward pain/sorrow is not, for Aquinas, intrinsically evil; because it is often an aid to self-preservation and to moral orientation toward virtue, it can be a virtuous and useful good. It is not, however, always so. Considering dolor and tristitia together, he

25 STh IaIIae q. 35 a. 7 resp. omnis plaga tristitia cordis est
26 The relevance of Aquinas’ analysis for the self-mutilating behavior of certain people in psychiatric contexts, such as those with borderline personality disorder, should be evident.
27 STh IaIIae q. 39 a. 1.
28 STh IaIIae q. 39 a. 2.
29 STh IaIIae q. 39 a. 3.
considers, and rejects, a moralistic view that pain or sorrow increases the power of learning (and so may always be used for beneficial moral ends). This is for Aquinas clearly not so; rather, pain and sorrow might so distract the soul that it is impossible for it to learn. Sorrow, in particular, can so burden the soul that its internal movements are “absolutely hindered;” in fact, “sometimes even the external movement of the body is paralyzed, so that a man becomes completely stupefied.” (Aquinas is likely here describing catatonia.) It is in the context of these descriptions that Aquinas devotes an entire subsequent question of the Summa (IaIIae q. 38) to remedies for sorrow which include virtuous pleasures, tears, the sympathy of friends, the contemplation of truth, and – as we have noted – sleep and baths, which function in part by restoring the vital movements of the body and bringing nature back to its normal state. Aquinas specifically rejects the argument that sleep and baths, because of their physicality, cannot affect interior dispositions of the heart: citing Aristotle, he affirms that “every good disposition of the body reacts somewhat on the heart, which is the beginning and end of bodily movements.”

Aquinas could not have imagined the development of physical agents more specific than baths for the remediation of excessive sorrow, but his discussion above, and especially his affirmation that sorrow can be so debilitating as to efface the capacity to learn, suggests that he would not have been averse to antidepressant agents or other somatic treatments such as ECT for the treatment of severe depression if the potential

30 *STh* IaIIae q. 37 a. 1 *obj. 1.*
31 *STh* IaIIae q. 37 a. 1 *resp.*
32 *STh* IaIIae q. 37 a. 2 *resp.*
33 *STh* IaIIae q. 38 a. 5 *resp.*
34 *STh* IaIIae q. 38 a. 5 *obj. 3, ad3.*
patient were suffering excessively, if the suffering were depriving him/her of the ability to learn and/or to attend to higher things, and if the sorrow had exhausted its value as a moral signal. Treatment with psychiatric technology, in this case, would support the person’s habituation in virtue and would palliate excessive and meaningless suffering.\textsuperscript{35}

9.2.2 Guideline 2. Decisions regarding psychiatric technology are prudential, rather than merely technical, decisions and so cannot be abstracted from context and from the habituation in virtue of the one who deliberates.

The argument of this concluding chapter, to this point, has been algorithmic and rule-driven. One first must clarify context, then clarify whether or not the experience and/or behavior in question is consistent with flourishing, then decide what, if any, variant of “mental disorder” is present, then decide whether the use of psychiatric technology would or would not be conducive to the flourishing of the potential recipient of the technology. Readers might think that, in the end, decisions regarding Christian uses of psychiatric technology can be reduced to a publicly-available algorithm and/or set of rules, such that even those with little prior training or experience in these questions could render sound judgments. But this is not the case, at least not within any Thomistic account. The reason has much to with Aquinas’ understanding of the virtue of prudence.

The virtue which Aquinas names prudentia is rooted in the classical tradition of the virtues and, in particular, in Aristotle’s concept of phronesis. In Book VI of the Nicomachean Ethics, Aristotle famously contrasts two modes of practical rationality: techne, or applied science, and phronesis, or practical wisdom. Techne – from which, of

\textsuperscript{35} This is also the view of Loughlin (2005); Stephen Loughlin, “Tristitia et Dolor: Does Aquinas Have a Robust Understanding of Depression?” Nova et Vetera 3 (2005): 761-784
course, the English term “technology” is derived – is the logic of poiesis, production, and is deeply familiar to anyone trained in modern biomedicine. *Techne*, for Aristotle, names the mode of practical reason in which (a) the end or goal is specified in advance of the application of “technology” or “method,” (b) the principal focus is on the best technology or method by which to achieve the pre-specified end, and (c) the successful application of the technology or method does not directly depend on the moral character of the agent.\(^\text{36}\)

Contrasted with *techne* is the somewhat different mode of *phronesis*, which Aristotle describes as a “truthful characteristic [or habit] of acting rationally in matters good and bad for man.”\(^\text{37}\) *Phronesis* is the virtue by which specific decisions are made regarding the good proper to humans, but importantly, and in contrast to the logic of *techne*, the proper good in a given situation cannot be specified prior to the deliberation of the *phronimos*, the person of practical wisdom: it emerges, rather, only in the deliberation of one who is able, through a lifetime of habituation in virtue, to discern the nature of the good in a particular situation.\(^\text{38}\) *Phronesis* therefore involves discernment of proximate ends as well as determination of means, and in contrast to *techne* cannot be abstracted from the moral character of the *phronimos*.

Aquinas is too much a Christian and an Augustinian to allow that the proper human good is determined in particular contexts by the *phronimos* – he is clear, as we have already discussed, that the proper good inheres in God and God’s eternal law – but


\(^\text{37}\) Nic. *Eth.* 1140b.

\(^\text{38}\) Nic. *Eth.* 1103b, 1104a, 1106b.
his account of prudentia nonetheless bears marked similarity to its Aristotelian precursor. Aquinas counts both prudentia and ars (the descendent of techne) as intellectual virtues assigned to the practical intellect; ars is the virtue concerning those things which are to be made, and prudentia is the virtue concerning those things which are to be done. The logic of ars is straightforward and technical: the end, the thing to be made, is clear, and the good of the art is to be found in this (pre-specified) end and not in the moral character of the producer. With regard to prudentia, however, the end – however grounded in eternal law – is not clear to the agent, and so it is important that the agent be well-disposed with regard to the end. This depends on the rectitude of the appetite, “wherefore, for prudence there is need of a moral virtue, which rectifies the appetite.”

Aquinas describes prudentia as right reason applied to action (recta ratio agibilium), the application of universal principles to the particular conclusions of practical matters. It belongs to prudentia, he says, to discern in what manner and by what means a person might obtain the mean of reason in his or her deeds. But prudential discernment is possible only in a person who (a) is sufficiently habituated into the moral virtues so as to be properly oriented to the good, and (b) who has acquired, through teaching and experience, the ability to select the right means for the attainment of the proper good.

Because the end of psychiatric decision-making is not a pre-specified product but rather the good of the patient, the most appropriate Thomistic model for psychiatric

39 STh IaIIae q. 57 a. 5 ad3.
40 STh IaIIae q. 57 a. 4 resp. Et ideo ad prudentiam requiritur moralis virtus, per quam fit appetitus rectus.
41 STh IaIIae q. 47 a. 2 sed contra.
42 STh IaIIae q. 47 a. 6 resp.
43 STh IaIIae q. 47 a. 7 resp. Sed qualiter et per quae homo in operando attingat medium rationis pertinet ad dispositionem prudentiae.
44 STh IaIIae q. 47 a. 15 resp.
practical rationality must be prudentia rather than ars. (The fact that the logic of ars/techne dominates the actual practice of biologically-oriented psychiatry, that writing in the model of ars/techne is the only form of scholarship that the biological psychiatry guild recognizes as relevant to its work, and that students and residents are frequently taught to understand psychiatry as a mode of ars/techne, is collectively the basis for a substantial critique of biological psychiatry which deserves more detailed and lengthy consideration than I provide here.) In the Thomistic sense the proper good of the person exists within the divine ratio but is in fact not known either by the person or by the clinician unless one or both of them is sufficiently habituated in virtue so as to be able to discern the good where it exists and to be able to deduce from the universal good to the particulars of the situation. Furthermore, one or both of them must have acquired the training and/or experience necessary for the selection of means for the attainment of the practical ends specified by the intellect. It follows from this, put simply, that (a) the moral character of the clinician (or whoever is doing the judging) matters, and that (b) the reason why the moral character of the clinician matters is that the proper good of the patient in any given situation is not necessarily clear-cut, and only a person sufficiently habituated in virtue can discern the nature of the good as it exists. This can only be done, however, in context, in the thick of a complex situation, and not through the development of a priori rules or algorithms. Algorithms can help to structure logical decision-making, and rules can set certain guidelines and outer boundaries for wise clinical decision-making, but Aquinas would hold that the question “Can this psychiatric technology be used appropriately in this situation” can satisfactorily be answered only in the moment,
enmeshed in the complexity of the situation, by a person (or persons) sufficiently
habituated in virtue, and specifically in the virtue of prudence, to be able faithfully to
discern both the nature of the good in the situation, and the appropriate means by which
to reach that good.

9.2.3 Guideline 3. Decisions regarding psychiatric technology must account for the
political character of the virtues and must acknowledge political incommensurability
when it exists.

In the *Nicomachean Ethics*, Aristotle is very clear that virtue demands a *polis* the
flourishing of which sets the proper *telos* of virtue. Politics, for Aristotle, is the
comprehensive master science, 45 and it is to become a competent student of politics that a
“proper upbringing in moral conduct” is necessary. 46 Humans are by nature political
beings; 47 the nature of virtue as that which “renders good the thing of which it is the
excellence and causes it to perform its function well” describes, primarily, the way that
human *arête* allows the human to function in the life of the *polis* in a way that leads to its
sustainable flourishing. 48

The political constitution of the virtues is not immediately as apparent in Aquinas’
account. Following Augustine and other Christian commentators, Aquinas consistently
locates the proper end of the virtues in God’s eternal *ratio*, not in the practical needs of a
human political community: virtue is, in the standard definition which Aquinas

45 Aristotle *Nic Eth.* 1094a.
46 Ibid. 1095b.
47 Ibid. 1097b.
48 Ibid. 1106a. This is all qualified, of course, by Aristotle’s endorsement of the self-sufficiency of the
contemplative life in *Nic. Eth.* X, though here he speaks of the intrinsic (rather than instrumental) reward of
the contemplative life over that of the statesman and military leader, and does not reject politics *per se*
(1177b).
incorporates into his work, “a good quality of the mind, by which we live righteously, of which no one can make bad use, which God works in us, without us.”

It is clear, however, that Aquinas does not reject the Aristotelian view and that it continues to operate within his discussion of the virtues; he allows, for example, that because humans are by nature political animals, “[God’s exemplar] virtues, insofar as they are in [the human] according to the condition of his nature, are called [political] virtues; since it is by reason of them that man behaves himself well in the conduct of human affairs.”

Similarly, he allows that the acquired (rather than infused) moral virtues “produce good works that are directed to an end not surpassing the natural power of man.” But this is especially clear in his discussion of the distinction between the infused and acquired virtues. The proper object of a virtue like temperance, he states, is the mean, but this may look markedly different in different moral contexts:

Now it is evident that the mean that is appointed [for temperance] in such like concupiscences according to the rule of human reason, is seen under a different aspect from the mean which is fixed according to the Divine rule. For instance, in the consumption of food, the mean fixed by human reason, is that food should not harm the health of the body, nor hinder the use of reason: whereas, according to the Divine rule, it behooves man to chastise his body, and bring it into subjection (1 Cor. ix. 27), by abstinence in food, drink and the like. It is therefore evident that infused and acquired temperance differ in species; and the same applies to the other virtues.

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49 *STh* IaIIae q. 55 a. 4 *resp.* He later clarifies that the last clause, “which God works in us, without us, applies only to the infused virtues; cf. IaIIae q. 55 a. 4 *ad6*.

50 *STh* IaIIae q. 61 a. 5 *resp.* Et quia homo secundum suam naturam est animal politicum, virtutes huiusmodi, prout in homine existunt secundum conditionem suae naturae, politicae vocantur, prout scilicet homo secundum has virtutes recte se habet in rebus humanis gerendis.

51 *STh* IaIIae q. 65 a. 2 *resp.*. Manifestum est autem quod alterius rationis est modus qui imponitur in huiusmodi concupiscentiis secundum regulam rationis humanae, et secundum regulam divinam. Puta in sumptione ciborum, ratione humana modus statuitur ut non noceat valetudini corporis, nec impediat rationis actum, secundum autem regulam legis divinae, requiritur quod homo castiget corpus suum, et in servitutem redigat, per abstinentiam cibi et potus, et aliorem huiusmodi. Unde manifestum est quod temperantia infusa et acquisita differunt specie, et eadem ratio est de aliis virtutibus.
He elaborates on this point by stating that a habit like “health” is also context-dependent, “for a man’s health and a horse’s are not of the same species, on account of the difference between the natures to which their respective healths are directed.” In the same way, Aquinas follows Aristotle in affirming that citizens have diverse virtues according as they are well directed to diverse forms of government. In the same way, too, those infused moral virtues, whereby men behave well in respect of their being fellow-citizens with the saints, and of the household of God (Eph. 2:19), differ from the acquired virtues, whereby man behaves well in respect of human affairs.

I cite Aquinas’s discussion here not to render a judgment on the thorny distinction in the *Summa theologiae* between the acquired and infused moral virtues, but rather to highlight that for Aquinas, as for Aristotle before him, speech about virtue demands consideration of the ends to which virtue is directed, which correlative entails a particular *civitas* organized around these specified ends.

This affirmation of the political contextualization of virtue leads to some very practical implications for the model of reflection regarding psychiatric technology which I outline here. Specifically, if virtue is a political concept unspecifiable apart from shared ends, any account such as the one I offer here which relies on habituation in virtue as a criterion for the appropriateness of psychiatric technology must take into account whether the clinician and patient in fact share a common *civitas*. If this is the case – if there is sufficient agreement regarding shared ends – then clinician and patient, happily, are free

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53 Ibid. . . non enim est eadem specie sanitas hominis et equi, propter diversas naturas ad quas ordinantur.
54 Ibid. Et eodem modo dicit philosophus, in III Polit., quod diversae sunt virtutes civium, secundum quod bene se habent ad diversas politias. Et per hunc etiam modum differunt specie virtutes morales infusae, per quas homines bene se habent in ordine ad hoc quod sint cives sanctorum et domestici Dei; et aliae virtutes acquisitae, secundum quas homo se bene habet in ordine ad res humanas.
to reflect and act along robustly normative lines. But often, as discussed in Chapter 4, clinician and patient will inhabit very different, and potentially deeply conflicting, political-ethical communities. Here the clinician is in a bind: he or she cannot render judgments about “mental disorder” or the appropriateness of particular psychiatric technologies without relying on teleological judgments regarding proper function; and yet, if he unilaterally invokes these teleological commitments, he or she does violence to the patient’s own normative commitments. In this event, several considerations apply.

First, when disagreement regarding ends arises in the context of psychiatric decision-making, these disagreements should be acknowledged and publicly named if, in the light of prudence, this can be done. Clinicians must be careful that this disclosure of disagreement does not itself become a locus of violence (a more powerful psychiatrist, for example, commending particular theological doctrines to a less-powerful and potentially vulnerable patient). In the context of a collaborative and respectful relationship, however, such disclosure can foster a kind of therapeutic honesty. It is especially important that clinicians not cover over disagreement about moral ends by the use of scientific-sounding recommendations (for example, “I don’t feel like this medication is right for you because I’m worried about excessive side-effects,” if this is not, in fact, what drives one’s reluctance to prescribe). Possible outcomes of a conversation like this include (a) mutual termination of the clinical relationship, (b) persuasion of either clinician or patient to adopt the perspective of the other, (c) clarification of what ends are shared in common, in addition to those which are not

shared in common, and/or (d) agreement on a strategy which respects the concerns of both clinician and patient.

Second, as discussed in Chapter 4, it is appropriate, in the face of disagreement about ends, to celebrate areas of common agreement which do exist. For example, a clinician and patient who do not share common agreement regarding the political and spiritual significance of marriage might still agree that this marriage is worth preserving, and that there are concrete steps which the patient can take toward this end. Such areas of agreement, where they exist, are to be celebrated. It is important, however, that neither Christian clinicians nor Christian patients act contrary to their understanding of virtue in the light of God’s eternal ratio: for Aquinas, unlike Aristotle, the virtues are not ontologically relative to the needs of particular political communities, but are rather inscribed in the eternal ratio.

Third, Aquinas’ account of the political constitution of the virtues underscores his consistent affirmation, discussed in Chapter 7, that humans are not isolated autonomous individua but, rather, are essentially social and political beings who must be understood in the context which constitutes them. Administering and/or receiving psychiatric technology is not, therefore, a strictly individual matter; it impacts not only the patient but those in his/her interpersonal world, for better or for worse. Prescribers of psychiatric technology, in particular, must always be aware of this sociopolitical dimension.
9.3 On Getting the Sacrament Right

In this concluding chapter, after summarizing the trajectory of the work so far, I have presented a framework, informed by thought by no means drawn directly from the thought of St. Thomas, for the way that Christians might think through the question, “Is the use of this form of psychiatric technology appropriate in this situation?” First, I have argued, one needs to clarify the context within which that question is asked in the first place, and also to render judgment about whether the experience and/or behavior of the person in that context is commensurate with virtue. If so, the only appropriate use of psychiatric technology would be to palliate excessive suffering and/or to support, by curbing certain of the body’s appetites, the soul’s orientation toward virtue (though not to the extent that moral habituation is rendered unnecessary). If not, two further questions need to be asked: (1) “Does this particular configuration of experience and behavior make sense as ordinary vice in this particular context, or do I find it unintelligible as such?,” and (2) “Are there specific reasons to think that medical/biological factors are contributing to this failure of flourishing?” The answers to these questions will help to clarify which of at least four conceptions of “mental disorder” might apply in the situation: (1) mental disorder as unintelligible contextual response (MD₁), (2) mental disorder as experience/behavior attributable to a known physiological/neurobiological lesion (MD₂), (3) mental disorder as deeply habituated vice (MD₃), or (4) mental disorder as excessive and extreme suffering (MD₄). Once this descriptive project is carried out, it becomes possible to consider whether, in the specific situation, the use of psychiatric technology is appropriate. I then proposed three guidelines which, collectively, can help
to inform and to regulate practical decision-making surrounding the use of psychiatric technology. First, psychiatric technology may be used when it helps, and does not hinder, participation in virtue. Second, decisions regarding psychiatric technology are prudential, rather than merely technical, decisions and so cannot be abstracted from context and from the habituation in virtue of the one who deliberates. Third, decisions regarding psychiatric technology must account for the political character of the virtues and must acknowledge political incommensurability when it exists.

I conclude this chapter – and the larger work of which it is a part – by noting, with some lament, how distant all of this seems from the language and the spirit of St. Thomas’ prayer, *Ante Communionem*, part of which forms the epigraph of this chapter. However much this account succeeds in appropriating Aquinas’ thought to modern contexts of psychiatric nosology and clinical decision-making, we are a long way from the large hunched-over frame of the Dominican priest and scholar, kneeling daily before the altar in devotion. Lest this be lost, therefore – lest Aquinas be used here as a kind of convenient, Christian modification of Aristotle who, at most, has some helpful philosophical things to say about the moral life – it is worth reflecting on this distance.

It is worth asking how St. Thomas would respond were he to miraculously appear in the middle of an annual meeting of the American Psychiatric Association, in a modern biologically-focused psychiatric unit, or in a bookstore with a prominent “Self-Help/Psychology” shelf. We can imagine that he might be amazed by and eager to learn more about developments in neuroanatomy, neurobiology, and especially molecular biology which, for him, would be an entirely new mode of investigation of the natural
world. We can imagine that he might be interested – perhaps cautiously so, but interested nonetheless – in the lessons which psychoanalytic thought and especially behaviorally-oriented experimental psychology have to teach about the habits and moral habituation, about the “emotions,” about the relationship between “emotion” and “cognition,” and about the formative effect of the social world on the organism’s life. But we can also imagine that he would be perplexed and disgusted at the way that psychiatric technology is granted, by some, an almost soteriological import. One wonders, for example, how St. Thomas would respond to the following paragraphs from a prominent article about depression (mentioned in Chapter 1) in a contemporary evangelical Christian magazine:

Don Timons, a top executive in an evangelical organization, had a reputation for a bad temper that led to lashing out at coworkers. For Timons, a decade-long depression expressed itself in an anger he felt unable to control. Repeated confessions of repentance for his inappropriate outbursts accompanied repeated pleas to God for help with his rage-to no avail.

Until Prozac.

Three weeks after having been prescribed the antidepressant Prozac, Timons felt an underlying change that mushroomed into a transformation “akin to how I felt during my conversion experience.” Not only did the depression lift, so did the uncontrollable anger.\(^{56}\)

It should be granted, of course, that this article was written in the heady early days of the serotonin-selective reuptake inhibitors immediately in the wake of Kramer’s sensational *Listening to Prozac*. No one, as of the writing of this work in 2011, seriously writes about fluoxetine or any other antidepressant drug in such euphoric terms. But the “Prozac craze” of the 1990s would not have had any traction had it not caught hold of a

deep-rooted cultural interest in finding a chemical solution for various forms of cultural, psychological, and spiritual brokenness.  

St. Thomas would have understood this desire, which was deeply consistent with his understanding of human nature: humans are, after all, embodied creatures who are sustained by material food and who take shape in relationship with other material bodies. Indeed, he even knew something about taking in a substance with soteriological power:

I answer [to the question of whether grace is bestowed through the eucharist] that the effect of the sacrament ought to be considered, first of all and principally, from what is contained in this sacrament, which is Christ; Who, just as by coming into the world, He visibly bestowed the life of grace upon the world, according to John 1:17: "Grace and truth came by Jesus Christ," so also, by coming sacramentally into man causes the life of grace, according to John 6:58: "He that eateth Me, the same also shall live by Me." Hence Cyril says on Luke 22:19: "God's life-giving Word by uniting Himself with His own flesh, made it to be productive of life. For it was becoming that He should be united somehow with bodies through His sacred flesh and precious blood, which we receive in a life-giving blessing in the bread and wine."

Secondly, it is considered on the part of what is represented by this sacrament, which is Christ's Passion, as stated above. And therefore this sacrament works in man the effect which Christ's Passion wrought in the world. Hence, Chrysostom says on the words, "Immediately there came out blood and water" (John 19:34): "Since the sacred mysteries derive their origin from thence, when you draw nigh to the awe-inspiring chalice, so approach as if you were going to drink from Christ's own side." Hence our Lord Himself says (Matt. 26:28): "This is My blood . . . which shall be shed for many unto the remission of sins."

Thirdly, the effect of this sacrament is considered from the way in which this sacrament is given; for it is given by way of food and drink. And therefore this sacrament does for the spiritual life all that material food does for the bodily life, namely, by sustaining, giving increase, restoring, and giving delight. Accordingly, Ambrose says (De Sacram. v): "This is the bread of everlasting life, which supports the substance of our soul." And Chrysostom says (Hom. xlvi in Joan.): "When we desire it, He lets us feel Him, and eat Him, and embrace Him."

57 Walker Percy, perhaps more than anyone else, brilliantly captured this in his late-twentieth-century novels.
And hence our Lord says (John 6:56): "My flesh is meat indeed, and My blood is drink indeed.

Fourthly, the effect of this sacrament is considered from the species under which it is given. Hence Augustine says (Tract. xxvi in Joan.): "Our Lord betokened His body and blood in things which out of many units are made into some one whole: for out of many grains is one thing made," viz. bread; "and many grapes flow into one thing," viz. wine. And therefore he observes elsewhere (Tract. xxvi in Joan.): "O sacrament of piety, O sign of unity, O bond of charity!"

And since Christ and His Passion are the cause of grace, and since spiritual refreshment and charity cannot be without grace, it is clear from all that has been set forth that this sacrament bestows grace. 58

There is, then, for Aquinas a life-giving substance, though it is not a technology of any sort, much less a psychiatric technology. It is, rather, a substance which is, literally, the body and blood of the One Whose incarnation, life, death, resurrection, and ascension enables corporeal, sinful humans, through grace, to participate the divine life.

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58 STh IIIa q. 79 a. 1 resp. Respondeo dicendum quod effectus huius sacramenti debet considerari, primo quidem et principaliter, ex eo quod in hoc sacramento continetur, quod est Christus. Qui sicut, in mundum visibiliter veniens, contulit mundo vitam gratiae, secundum illud Ioh. I, gratia et veritas per Iesum Christum facta est; ita, in hominem sacramentaliter veniens, vitam gratiae operatur, secundum illud Ioh. VI, qui manducat me, vivit propter me. Unde et Cyrilrus dicit, vivificavitum Dei verbum, uniens seipsum propriae carni, fecit ipsam vivificativam. Decebat ergo eum nostris quomodum uniri corporibus per sacram eius carmen et pretiosum sanguinem, quae accipimus in benedictione vivificativa in pane et vino. Secundo consideratur ex eo quod per hoc sacramentum repraesentatur, quod est passio Christi, sicut supra dictum est. Et ideo effectum quem passio Christi fecit in mundo, hoc sacramentum facit in homine. Unde super illud Ioh. XIX, continuo exivit sanguis et aqua, dicit Chrysostomus, quia hinc suspiciunt principium sacra mysteria, cum accesseris ad tremendum calicem, vel ab ipsa bibiturus Christi costa, ita accedas. Unde et ipse dominus dicit, Matth. XXVI, hic est sanguis meus, qui pro vobis effundetur in remissionem peccatorum. Tertio consideratur effectus huius sacramenti ex modo quo traditur hoc sacramentum, quod traditur per modum cibi et potus. Et ideo omne effectum quem cibus et potus materialis facit quantum ad vitam corporalem, quod scilicet sustentat, auget, reparation et delectat, hoc totum facit hoc sacramentum quantum ad vitam spiritualem. Unde Ambrosius dicit, in libro de sacramentis, iste panis est vitae aeternae, qui animae nostrae substantiam fulcit. Et Chrysostomus dicit, supra Ioh., praestat se nobis desiderantibus et palpare et comedere et amplecti. Unde et ipse dominus dicit, Ioh. VI, caro mea vere est cibus, et sanguis meus vere est potus. Quarto consideratur effectus huius sacramenti ex speciebus in quibus hoc traditur sacramentum. Unde et Augustinus, ibidem, dicit, dominus noster corpus et sanguinem suum in eis rebus commendavit quae ad unum aliquod rediguntur ex multis, nuncupate aliud, scilicet panis, ex multis granis in unum constat, aliud, scilicet vinum, ex multis racemis confluit. Et ideo ipse alibi dicit, super Ioh., o sacramentum pietatis, o signum unitatis, o vinculum caritatis. Et quia Christus et eius passio est causa gratiae, et spiritualis refectio et caritas sine gratia esse non potest, ex omnibus praemissis manifestum est quod hoc sacramentum gratiam contert.
It is bodily, but much more than body; it satisfies the senses, and yet relativizes them. It draws the participant outward, and upward, and inward – no directional metaphor seems to suffice – but it does not leave the participant where he or she is. Take this material substance into your body, Aquinas offers, and be graciously reminded that you are much more than a body which takes material substances into your body. You are a wayfarer on a journey to your source and end, in Whose life you are, through grace and the sacraments, already a proleptic participant.

Christians may make use of psychiatric technology, but technology cannot lead humans to their final end. Psychiatric technologies can tweak the brain’s mood-regulation, anxiety-generating, and perceptual systems, among other things, but they cannot elevate humans above their nature and they cannot replace the sacraments that God has provided for human viatores. St. Thomas Aquinas, whose precise Aristotelian theorizing was contextualized by daily reception of that life-giving substance, would want to remind modern technologically-oriented Christians of that. *Signatum est super nos lumen vultus tui, domine,* Aquinas loved to say, quoting the Vulgate’s rendering of Psalm 4:6: “the light of your countenance, O Lord, is signed upon us.” The human intellect receives its light not from anything material but from the intellectual light, God, Who is the source of all light. If psychiatric technology, through removing certain barriers and providing certain supports, can aid human wayfarers in the reception of that light, then it can be received as providential gift. But it is not, itself, the light.

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59 *STh* IIIa q. 79 a. 4 *resp.*
Appendix

Figure 1. Algorithm for Clarification of Context, Consistent with Thomistic Principles

(1) “What is the moral context within which this person finds himself/herself/myself?”

(2) “What range of experience and behavior do I understand to be commensurate with this particular moral context?”

(3) “Is the experience and behavior in question consistent with virtue in this particular context?”

Virtue

No

Failure of flourishing

Yes

Excessive suffering?

Yes

(4a) “Does this particular configuration of experience and behavior make sense in this context as ordinary vice?”

Yes

(4b) “Are there specific reasons to think that medical/biological factors are contributing to this failure of flourishing?”

No

Mental Disorder$_4$ – Extreme suffering without moral value

Mental Disorder$_3$ – failure of flourishing due to extrinsic physiological cause

Mental Disorder$_2$ – deeply habituated vice

Mental Disorder$_1$ – Unintelligible Contextual Responses

No

Yes

Yes

No
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Biography

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