ARE MENTAL DISORDERS NATURAL KINDS?
A Plea for a New Approach to Intervention in Psychiatry

Serife Tekin

ABSTRACT: Both proponents and opponents of the claim that mental disorders are natural kinds compare mental disorders to paradigmatic examples of natural kinds, to inquire into a set of properties that achieve three scientific tasks: explanation, prediction, and intervention. I argue that the comparative strategy fails to take us to any intervention-related properties of mental disorders. I replace it with what I call a trilateral strategy—a strategy guided by first-person accounts of individuals with mental disorders, and the relevant clinical and scientific work on psychopathology. I illustrate how the trilateral strategy works with a focus on schizophrenia—an example used by both sides of the debate.

KEYWORDS: Natural kinds, mental disorders, looping effects, schizophrenia, intervention

MENTAL DISORDER is an urgent and growing public health problem.¹ Scientific investigation of this problem has the pragmatic goals of identifying the causes of mental disorders and developing strategies to effectively treat them. Philosopher of psychiatry have participated in the inquiry into the empirical examination of mental disorders, predominantly by debating whether psychopathology is a legitimate target of scientific inquiry and, if so, how mental disorders should be explained, predicted, and intervened on. However, as I show in this paper, these philosophical discussions have mostly neglected the actual state of inquiry in psychiatry and relevant disciplines, as well as the first-person experiences of those with psychopathology.

A prominent view in the literature is that whether something can be empirically investigated depends on whether or not it is (or involves)² a natural kind (Cooper, 2004a, 2004b, 2007; Samuels, 2009). Members of a particular natural kind are thought to share a large number of logically unrelated and scientifically important properties (or relations) that enable the formulation of successful scientific generalizations. Accordingly, if mental disorders are natural kinds, the discovery of the scientifically relevant properties that their members share should yield successful explanations,
reliable predictions, and effective interventions (Cooper, 2004a, 2004b, 2007; Samuels, 2009). Thus, the scientific legitimacy of mental disorders has hinged on their status as natural kinds.

Proponents and opponents of the view that mental disorders are natural kinds participate what is called the Looping Debate (Tekin, 2014). They inquire into the scientifically relevant properties that will facilitate explanations, predictions, and interventions in psychiatry by adopting what I call the comparative strategy. They evaluate whether mental disorders, such as schizophrenia, are ‘fundamentally like or unlike kinds such as chemical elements, fundamental particles and biological species’ (Cooper, 2004a, p. 76), and compare mental disorders to the paradigm examples of the natural kinds studied by other sciences to draw inferences about their empirical investigatibility (Hacking, 1986, 1995a, 1995b; Cooper, 2004a, 2004b, 2005, 2007; Bogen, 1988; Douglas, 1986; Samuels, 2009; Zachar, 2000). Proponents of the Looping Argument (LA) argue that mental disorders are not natural kinds because members of psychiatric kinds change in response to their scientific labels, whereas natural kinds are not subject to such looping effects (Hacking, 1986, 1995a, 1995b). Being subject to looping effects make the properties of psychiatric kinds unstable, and thereby unfit for developing successful explanations, reliable predictions, and effective interventions in psychiatry. Proponents of the Parity Argument (PA) object to the LA, and argue that some natural kinds are also subject to looping effects, and this is not an obstacle for their scientific investigation (Cooper, 2004a, 2004b, 2005, 2007; Khalidi, 2010). Thus, having unstable properties does not rule psychiatric kinds out as legitimate targets of scientific inquiry.

The target of criticism in this paper is the claim that the comparative strategy will take us to a set of properties that achieve three tasks: explanation, prediction, and intervention in psychiatry. In the second section, I show that this is false; the Looping Debate’s use of the comparative strategy fails to take us to the properties relevant for intervention in psychiatry. In the third section, I propose a trilateral strategy that examines the scientific and clinical work on mental disorders as well as first-person accounts of those with such disorders. Using schizophrenia as an example, I illustrate that the trilateral strategy takes us to properties instrumental for developing effective interventions on mental disorders—without having to settle their natural kind status. I remain neutral on whether the comparative strategy is useful for arriving at properties relevant for explanation and prediction. My argument is that those properties relevant to intervention are bona fide scientific properties.

Mental Disorders and Natural Kinds

The Appeal of Natural Kinds in Philosophy of Psychiatry

Psychiatry, as a branch of medicine, has the pragmatic goal of alleviating the burden of mental disorders on individuals so affected. Scientific research agenda is guided by this medical maxim: inquiry in psychiatry and other relevant disciplines such as neuroscience seeks to explain what mental disorders are, track their etiology, predict their course, and develop effective interventions.

For instance, the goal of psychiatric taxonomy is to formulate useful categories of mental disorders, such as schizophrenia. Usefulness of a category (psychiatric kind) is contingent upon its power to guide research, diagnosis, and clinical treatment, and to inform various policy related contexts. The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA), is developed for such purposes. The DSM uses a categorical schema in which each psychiatric kind is individuated by a list of criteria identifying the symptoms (observed by the patient) and signs (observed by others) (APA, 2013, 1994). The DSM categories are operationally defined and, as such, they are subject to change in light of new empirical data. In fact, the DSM is regularly revised; currently, there are five editions. A fundamental assumption is that, as science progresses, it will be possible to discover the etiology underlying each psychiatric kind and, thus, to eventually construct a classificatory system based on true natural similarities and differences between various mental disorders. Until then, categories will continue to be revised
to ensure that they have “an extensive empirical foundation,” and are useful for “clinical, research, and educational purposes” (APA, 1994, p. xxiii).

Philosophers have long been interested in the metaphysical and epistemological issues of psychiatric classification and have debated the status of mental disorders as legitimate targets of scientific inquiry by invoking natural kinds (e.g., Cooper, 2004a, 2004b, 2007; Hacking, 1986, 1995a; Graham, 2010; Kendler, Zachar, Craver 2010; Samuels, 2009; Zachar, 2000). The concept of the natural kind is appealing because of its conceived usefulness in scientific generalizations. Members of a particular natural kind are thought to share a large number of scientifically relevant properties that ground scientific explanations, predictions, and interventions. A prominent view in philosophy of psychiatry is that if mental disorders are natural kinds, the discovery of their shared properties can yield explanations, predictions and interventions (Cooper, 2004a, 2007; Samuels, 2009). Rachel Cooper writes:

If mental disorders are natural kinds, we may then hope for ... explanations and predictions in psychiatry. If bipolar disorder, say, turns out to be a natural kind, then we can explain why it is that a particular case unfolds as it does. We can say that someone suffers from alternating manic and depressive phases because they have bipolar disorder. We will also be able to make various predictions, for example, if someone suffers from bipolar disorder then lithium treatment might help. Where mental disorders are natural kinds, this will give us some control over them. In particular, treatments that work for one of the kind can be expected to work for all of the kind. (Cooper, 2007, pp. 63–64)

The motivation to attribute natural kind status to mental disorders, therefore, originates from the desire to make them amenable to manipulation. If the scientifically relevant properties of bipolar disorder are identified (by deeming them natural kinds), we can formulate scientific explanations, offer predictions about their course, and develop interventions.

However, the definition of natural kind itself is neither unambiguous nor uncontested. The biggest challenge for a philosopher who inquires the natural kind status of mental disorders is to adjudicate among the various characterizations of natural kinds in the literature. Philosophers dis-agree about the properties that a class of individuals must possess to be considered a natural kind (Cooper, 2004a, 2007; Graham, 2014; Hacking, 1991; Khalidi, 2010; Machery, 2009; Samuels, 2009). Consider a few approaches. According to essentialists, a class of individuals is a natural kind if the shared properties of its members ‘carve the nature at its joints,’ to use Plato’s memorable image (Wilkerson, 1995). The view is that the members of the class share intrinsic, microphysical, stable, and mind-independent properties that are necessary and sufficient for membership in the kind. According to the homeostatic property cluster view, natural kinds are groups of entities that share stable cluster of similarities. These similarities must be stable enough to allow reliable predictions about various properties of a kind (e.g., Boyd, 1991; Machery, 2009). If we know Ludwig is a cat, we can predict him having two eyes. Unlike the essentialist view, the homeostatic property cluster view approach does not require these properties to be necessary and sufficient for the kind membership. Rather, the members share an ‘underlying mechanism,’ making their properties generalizable. The members of Canis familiaris, for example, share a number of properties (having four legs, etc.), but given the forces of evolution, no one biological property, nor a unique set of properties that are each necessary and jointly sufficient, is essential for species membership.

The lack of consensus on the definition of natural kinds complicates the evaluation of mental disorders’ natural kind status. What does a philosopher commit to when she claims that mental disorders are natural kinds? Are mental disorders natural kinds with sets of essential properties shared by all individual members of the class, that are also necessary and sufficient for kind membership? Or alternatively, are they natural kinds sharing a number of stable property clusters with an underlying mechanism, thus allowing scientific generalizations? Philosophers of psychiatry recognize the significance of this problem and adopt what I call the comparative strategy to circumvent the obstacle. The Looping Debate embodies this strategy in its quest for properties relevant for explanation, prediction, and intervention in psychiatry. As I show, however, this strategy is
not successful at arriving at intervention-related properties of mental disorders.

**The Comparative Strategy and Looping Debate**

Looping Debate occurs between the proponents of the LA and the PA. They both use the comparative strategy to avoid the ambiguity of the concept of natural kind; that is, they juxtapose mental disorders against paradigm examples of natural kinds, such as chemical elements and biological species, and argue for or against the claim that mental disorders are natural kinds (Cooper, 2004a, 2004b, 2007; Hacking, 1986, 1995a; Samuels, 2009). For example, a proponent of the LA, Ian Hacking, acknowledges the lack of consensus on the concept of natural kind. He uses paradigmatic examples of natural kinds while arguing against the claim that some human kinds, namely, the phenomena related to human beings, their actions, sentiments, and mental disorders, are natural kinds. He compares human kinds, including mental disorders, with examples of what he takes to be natural kinds, such as mud and thyrotropin-releasing hormones (Hacking, 1995a, pp. 367–368). Cooper, a proponent of the PA, in defending that mental disorders are natural kinds, also avoids the complexities involved in defining natural kinds:

As the debates over natural kinds have been intense and are ongoing, it is unlikely that any particular account of natural kinds will become generally accepted in the near future. Given this uncertainty concerning the nature of natural kinds, is there any way of determining whether human kinds are natural kinds? Don't we need to get straight about natural kinds before we can decide whether human kinds are distinct? Fortunately ... there is a means by which we can sensibly ask whether human kinds are natural kinds in the absence of an agreed account of natural kinds ... we can point to some paradigmatic examples of natural kinds—chemical elements, fundamental particles, and biological species. As such, we can ask whether human kinds are distinct from natural kinds via considering whether human kinds are fundamentally like or unlike kinds such as chemical elements, fundamental particles and biological species. (Cooper, 2004a, p. 76)

Regardless of which side of the debate philosophers are on, therefore, the strategy to get at the scientifically relevant properties in psychiatry has been to investigate whether and how mental disorders are 'fundamentally like or unlike' the kinds studied by natural sciences.

According to the LA, mental disorders are not natural kinds, precisely because the properties of individuals who are subject to psychopathology change in response to the scientific labels they are given—sometimes because these individuals are aware of their labels. This leads to changes in the very properties that characterize mental disorders (Hacking, 1986, 1999, 1995a, 1995b). Changes in the properties of the kind members become significant over time, necessitating the reassessment of the initial kind description. After re-evaluation, scientists are forced to alter the definition of the psychiatric kind. Thus, there is an interactive loop between a psychiatric kind, such as multiple personality, and the individual members of the kind, that is, individuals with multiple personality (Hacking, 1995b).

The exhibition of looping effects is not exclusive to mental disorders. Rather, it is a phenomenon common to Hacking's human kinds, including mental disorders. Hacking's early formulation of this phenomenon is as follows:

Responses of people to attempts to be understood or altered are different from the responses of things. This trite fact is at the core of one difference between the natural and human sciences... There is a looping or feedback effect involving the introduction to classifications of people. New sorting and theorizing induces changes in self-conception and in behaviour of the people classified... Kinds are modified, revised classifications are formed, and the classified change again, loop upon a loop. (Hacking, 1995a, p. 370; emphasis mine)

How exactly do the properties shared by the members of a psychiatric kind (e.g., awareness, self-conception, and behavior) change upon these individuals' identification as members of that kind? Hacking discusses the trajectory of this interaction primarily through examples, such as multiple personality, child abuse, refugee status, and schizophrenia. However, in these examples, he does not articulate explicitly how the properties of the individual members of the psychiatric kind change in response to being classified. In particular, he does not engage with the question
of precisely what it is about the self or the subject that makes her amenable to developing responses to classifications (Tekin, 2014).

Based on his exemplifications, we see that looping effects have two arcs (Hacking, 2004). The first is constituted by the influence of classifications on the individuals so classified, and the second captures the eventual influence of the changes by the individuals on the initial descriptions of the classifications. Consider the first arc. In the examples of the phenomena that are subject to looping effects, Hacking refers to the changes in self-concepts, changes in behavior, and changes in awareness as the main parameters of the alterations observed in individuals upon being classified. As he explicitly states in the above citation, "new sorting and theorizing induces changes in self-conception and behavior of the people classified" (Hacking, 1995a, p. 370). He is more ambiguous about awareness. In his example of women refugees' being subject to looping effects, he states that 'awareness' is not necessary for looping effects; that is, even though women refugees are unaware of how they are classified, because they do not know English, they do change in response to their labels (Hacking, 1999, p. 32). Yet in his argument against the claim that microbes are also subject to looping effects, because they mutate in response to medications, Hacking states that microbes do not change because they are aware of what is being done to them (Hacking, 1999, p. 106). Thus, in the microbe example, he takes awareness as a necessary component of looping effects.

Another important point to make about the first arc of looping effects is that sometimes individuals respond consciously (or explicitly) to their labels, and this reaction can occur unconsciously (or implicitly). In some of his examples, Hacking highlights the classified individual’s conscious and immediate reaction to being classified as the main 'engine' generating looping effects (Hacking, 1995a, 1995b, 2007). An example appears in Hacking’s discussion schizophrenia:

We need ... to realize that the classification as schizophrenic ... [is a matter] of which the patients, for all their periodic deficits of logic and sense of reality, are intensely aware. More of them are more aware now than they used to be... The schizophrenic, as a kind of person, is a moving target, and the classification is an interactive kind. (Hacking, 1999, p. 114)

In other examples, Hacking highlights individuals’ unconscious reactions to their labels, highlighting the significant role played by social and cultural factors, such as his discussion of the influence of being classified as refugees on women refugees (Hacking, 1999). Here, he emphasizes the indirect and unconscious effect of classification on the subject via society and culture. As discussed elsewhere, Hacking emphasizes how the classification (or naming) changes the subject's epistemic and moral relations with herself (Tekin 2010, 2014). In other words, the category (the outcome of scientific query) into which the subject is placed, leads her to reflect on and judge herself differently. Being classified as A changes how A 'thinks' about herself and her 'self-worth':

Such self-related epistemic and moral changes are generated through the scientific knowledge of the categories and are mediated qua self and qua others (who share the same cultural and linguistic community). Thus, in human kinds, naming and classifying qua-self and qua-others change the person. (Tekin, 2014)

It is plausible, then, to suggest that both personal and cultural and social factors are important aspects of the looping trajectory. In addition, both conscious and unconscious cognitive processes are involved in the changes generated by the classifications.

The existence of looping effects is considered a prima facie impediment to the legitimacy of psychopathology as target of scientific explanation, prediction, and intervention. If psychiatric kind X is sensitive to how those with X respond to being X, it means that X lacks stable property clusters. This is assumed to be problematic, because without stable properties, scientific explanations, predictions, and interventions cannot be made. The proponents of the PA, some of whom support the view that at least some mental disorders are natural kinds, deflate the significance of the phenomenon of looping effects by arguing that looping effects in natural kinds are on a par with the looping effects in human kinds (Bogen, 1988; Cooper, 2004a, 2007; Douglas, 1986; Khalidi, 2010). Thus, the reasoning goes, the existence of
The core idea of the comparative strategy is that looping effects do not pose a challenge to explanation, prediction, and intervention in psychiatry. This view can be illustrated as follows. Researchers of infectious diseases continue to conduct research on microbes, even though microbes have unstable properties, that is, they respond to being classified by mutating in response to the medications scientists give them. Similarly, mental disorders can be characterized as natural kinds subject to looping effects. PA proponents direct their efforts, therefore, to showing that the exhibition of looping effects is not limited to human phenomena. They use the comparative strategy to illustrate that the exhibition of looping effects is also a feature of various natural kinds. Comparing the paradigm examples from the natural kind family with Hacking’s human kinds, including mental disorders, they argue that scientific practices in natural sciences also result in looping effects, and our classifications also alter some natural kinds. Some examples include the effect of being classified as harmful on microbes, the influence of legal bans on the shape of marijuana, the influence of selective breeding on animals, and the effect of training on the domestication of dogs (Bogen, 1988; Cooper, 2004a, 2004b, 2007; Douglas, 1986; Khalidi, 2010). Hence, the conclusion of PA is that being subject to looping effects does not rule mental disorders out of the natural kind family (Cooper, 2004a, 2004b, 2007). In response, LA proponents challenge the examples of looping effects in natural kinds by making further comparisons between the so-called human kinds and natural kinds.

**The Comparative Strategy’s Failure**

The Looping Debate’s use of the comparative strategy fails to identify the properties relevant for intervention in psychiatry. This is because such comparisons have been asymmetrical; the debate’s primary emphasis has been on the properties of paradigmatic natural kinds. The properties of mental disorders relevant for intervention are overlooked because there has not been a direct investigation of scientific and clinical work on mental disorders as well as first-person accounts. Yet each deals with effective interventions to psychopathology. At the root of the comparative strategy’s failure is its false assumption that most mental disorders exhibit looping effects. Instead of investigating whether the exhibition of looping effects is a generalizable feature of mental disorders—with a direct investigation of scientific and clinical work and first-person accounts—the debate focuses on whether paradigmatic natural kinds, such as marijuana, microbes, and bred dogs are subject to looping effects. I remain neutral on whether the comparative strategy is useful for arriving at properties relevant for explanation and prediction. My argument is that it is not for the case of intervention even though those properties relevant to intervention are bona fide scientific properties.

**The Trilateral Strategy to Find the Scientifically Relevant Properties in Psychiatry**

Some philosophers have moved away from the comparative strategy given the challenge of dealing with ambiguous descriptions of natural kinds when adjudicating the status of psychiatric kinds. Notably, Peter Zachar develops a scientifically inspired pragmatic view according to which mental disorders are members of an ‘imperfect community’; there is no set of properties that all psychiatric disorders have in common and that distinguishes them from non-disorders (Zachar, 2014, p. 125). Zachar asserts that demanding that psychiatric kinds conform to a natural kind model is conceptually conservative, because it “confines construct of psychiatric disorder into a tight conceptual space” (Zachar, 2014, p. 156). He argues that mental disorders are practical kinds; psychiatric classifications must address multiple and sometimes competing goals, and that selecting a classification can involve balancing those goals against one another. Thus, by taking mental disorders to be members of an imperfect community, philosophers can make use of concepts including not only that of natural kind—which Zachar takes to be metaphysically loaded—but also of historicity, normativism, and practical kind. According to Zachar, adopting this pluralistic approach would give us more information about the scientific
features of mental disorders. I am in agreement with the basic features of Zacher's approach. My challenge against the comparative strategy, as well as the trilateral approach I propose, is a pluralistic approach that engages directly with the scientific and clinical research on mental disorders. In this sense, it aligns with his scientifically inspired pragmatism. Moreover, my approach also seeks the features of mental disorders that are instrumental for developing effective interventions, with "no expectation that the distinctions will be universally valid or lacking exceptions" (Zachar, 2014, p. 122). However, I depart from Zachar in that I argue that the properties relevant for explanation, prediction, and intervention need not overlap: some work may target properties relevant for explanation (e.g., genetic lineage), some may target those fit for prediction (e.g., neural circuits), and yet others may target those relevant for intervention (e.g., self-concepts). In other words, I believe that the scientific goals of explanation, prediction, and intervention are not always met with a focus on the same set of properties that individuate a particular mental disorder. For example, based on the scientific knowledge we acquire about the course of Alzheimer's disease, such as its genetic etiology, we can make predictions about how an Alzheimer's patient's condition will unfold over time; however, these very properties may not be instrumental for effective intervention. In other words, it is plausible to imagine scenarios where the properties that yield to successful prediction are distinct from the properties that facilitate intervention. We might predict the course of Alzheimer's disease in an individual by looking at her genetic information and family history of the same illness, yet we may have to use drugs that target the brain, instead of genes, to intervene successfully. Our prediction is then based on gene-related properties, whereas our intervention is based on neural properties of the same condition. This leaves open that the comparative strategy may be suitable for arriving at properties relevant for explanation and prediction—I do not focus on it here—although it fails to arrive at properties relevant for intervention.

The trilateral strategy promotes the examination of the scientific and clinical work involving individuals with mental disorders, as well as their first-person reports. These epistemic sources shed light into developing effective interventions as they disclose, respectively, what may be the underlying causes of mental disorders, how to effectively treat them, and what it may be like to be someone with a mental disorder. Although the information obtained from these third-person and first-person perspectives is not exhaustive, it reveals to us more about the properties important for intervention in psychiatry than is obtained by using the comparative strategy. Three epistemic sources together are especially important for guiding and assisting interventions in psychiatry, because they help to assess therapeutic successes and failures. In addition, by appealing to the scientific and clinical work, and the first-person accounts, we do not need to have to arrive at a consensus on the definition of natural kinds to determine the relevant properties in psychiatry.

I use schizophrenia to illustrate the trilateral strategy. Reasons for focusing on schizophrenia are pragmatic. Schizophrenia is used to advance both LA and PA, that is, both proponents and opponents of the claim that mental disorders are natural kinds use schizophrenia to illustrate their respective arguments (Hacking, 1999; Cooper, 2005; Samuels 2009). In addition, there is a burgeoning literature that features the first-person accounts of individuals diagnosed with schizophrenia and an expanding body of medical and scientific work involving these individuals.

The trilateral strategy is stronger than the comparative strategy, not only because it takes us directly to the concepts that characterize the scientifically relevant properties in psychiatry—instead of reviewing the features of paradigmatic natural kinds—but because it also corrects the false assumption of the Looping Debate. It illustrates that looping effects are not generalizable features of mental disorders. In addition, by directly engaging with scientific and clinical work, and first-person accounts, the trilateral strategy shows that the instability of psychiatric kinds is not an obstacle to developing interventions—an issue that has remained unexamined in the Looping Debate. LA proponents have considered the existence of looping effects an impediment to the scientific
study of psychopathology; however, they do not investigate whether this is true for all mental disorders in the contexts of explanation, prediction, and intervention. PA proponents, on the other hand, do not seem to take instability of a kind to be an obstacle for its scientific investigation; however, their discussion remains limited because they target primarily the paradigmatic natural kinds, such as marijuana and bred dogs, and show how their instability is not an impediment to their natural kind status. They remain silent on whether the instability of psychiatric kinds is an impediment to their scientific scrutiny, in the contexts of explanation, prediction, and intervention. The trilateral strategy, as discussed below, shows that the instability in kindhood is not an obstacle to developing effective interventions.\textsuperscript{11}

**Schizophrenia and Awareness**

Schizophrenia typically appears in early adulthood, with some early cases arising in the mid-teen years. According to the *DSM-IV-TR*, there are five ‘characteristic’ symptoms of schizophrenia: 1) delusions, 2) hallucinations, 3) disorganized speech, 4) grossly disorganized or catatonic behavior, and 5) negative symptoms—affective flattening, alogia (poverty of speech), or avolition (inability to initiate or persist in goal-directed activities).

Are most individuals with schizophrenia aware of their illness and diagnosis, as assumed by the participants of the Looping Debate?\textsuperscript{22} The trilateral strategy shows that this is mistaken; awareness is not a generalizable feature. Some individuals with schizophrenia are fully aware of their illness and the diagnosis they are given, as well as how these influence their lives. Elyn Saks, an individual with schizophrenia writes:

Since the earliest days of my illness, I had kept most of the details (of my behavior, of the various diagnoses, of all the doctors, of my therapy sessions) away from my parents. The reasons were ... complicated. First, I was ashamed; surely someone of my intelligence and discipline should be able to exert more power over herself. Second, I didn’t want to worry them; they had two other children, a business to run, and their own lives to lead. After all, I was an adult, and so far I’d managed ... to accomplish two fairly rigorous academic degrees. (Saks, 2007, p. 153)

Saks states that, since the onset of her illness, she was aware, albeit minimally, that there was something wrong with her mind. The illness expressed its severity in a flood of hallucinations and delusions when she was at Oxford studying philosophy. Throughout her life, she was aware that she had a serious illness. She was also aware of the various diagnoses she was given, for example, her diagnosis under the psychoanalytic framework, as well as the DSM diagnosis. She looked for various forms of treatment, after these diagnoses, while struggling to establish her life withstanding her illness.

A member of the Voice Hearers’ Movement in Europe responds similarly to her illness and diagnosis:

I’d been battered with shock treatments ... [O]ne day ... the intern came in to check on me ... He told me that he’d heard that there were self-help groups from people who heard voices. He thought I might benefit from attending one ... It turned out that a group was just starting at my local day center. A staff member there gave me a book called *Accepting Voices* by a doctor in Holland called Marius Romme. Someone came down from Manchester to help us; group get organized. He said ... our group was one of the 150 voices support groups across Britain. I thought I’d faint. I had no idea that there were so many other people struggling with the same problem as I was. (Hornstein, 2009, p. 7)

This patient, like Saks, is aware of her illness and actively seeks help. Patients like these two, more or less, maintain self-awareness, notwithstanding their illness. They are aware of the changes they are subject to owing to schizophrenia.

However, the clinical work on and the scientific research into schizophrenia suggests that illness and diagnosis awareness is not a generalizable feature of schizophrenia, challenging the participants of the Looping Debate. Some individuals with schizophrenia are subject to anosognosia—a lack of awareness of mental disorder, its symptoms, and its severity (Amador & David, 2004; Jorgensen, 1995). This phenomenon is reported to affect approximately 50% of those with schizophrenia (NAMI, 2005). Such individuals are usually not aware that their hallucinations or delusional beliefs do not cohere with reality. The stories of these patients usually unfold in the following way. Facing serious disruptions in their daily function-
ing owing to hallucinations and delusional beliefs, they are hospitalized, and in some cases, put on medications. During their time at the hospital and upon being released, they continue to deny that they have a serious illness.

There is also emerging neuroscientific work on awareness and schizophrenia. Research indicates that this phenomenon is not simply illness denial or psychodynamic construal, nor is it stubbornness or a personality quirk. Some findings point to frontal lobe area damage, which is similar to anosognosia resulting directly from brain injury, such as a stroke (Lele & Joglekar, 1998; Rickelman, 2004). Stroke patients with anosognosia often act as though they know nothing about the paralysis or they have unrealistic beliefs about their paralyzed limbs. Similarly, psychotic patients lack awareness of their illness even in the face of compelling evidence, and they confabulate to explain away any observations that suggest that they are ill. Amador and Johanson (2000) report the case of a 71-year-old patient with a right hemisphere lesion who was unaware of motor impairments and sensory loss and insisted that he was in the hospital for a hip replacement. Similarly, a 26-year-old man with schizophrenia was involuntarily committed during a psychotic episode and stated that he was hospitalized in a psychiatric ward because all the other beds in the hospital were full (Amador & Johanson, 2000).

According to a recent neuroscientific study that explores the role of the brain's default network system in psychopathology, anosognosia in schizophrenia is associated with impaired cerebral blood flow in the precuneus in the superior parietal area. The precuneus is considered to be involved in episodic memory and reflections upon the self. In this study, the blood flow in the precuneus of patients with schizophrenia and anosognosia was compared with that of patients with schizophrenia but without anosognosia, and control individuals (without schizophrenia). Patients with anosognosia were found to have significantly decreased blood flow to the precuneus (Faget-Agius et al., 2012).

Note that neuroscientific research on anosognosia is in its infancy (Buckner, Andrews, & Schacter, 2008). The concept remains vague, and the experimental paradigms designed to identify the underlying neural mechanisms may not be adequate. However, using the trilateral strategy, we do have grounds to falsify the Looping Debate's assumption that most individuals with schizophrenia are aware of their condition.

Schizophrenia Awareness and Intervention

Can the presence or the absence of illness and diagnosis awareness be taken as possible properties of schizophrenia that can help to advance intervention strategies? This question has remained unexamined in the Looping Debate. Clinical and scientific evidence, as well as the first-person reports, illustrate that intervention on schizophrenia is possible in both cases. In fact, the absence or presence of awareness is a good indicator for determining which treatment methods might help. Thus, the instability caused by the presence of illness and diagnosis awareness, which causes the psychiatric kind to change, is not an impediment to the development of effective strategies for treating schizophrenia—a point not settled by the comparative strategy.

Consider the scenario in which schizophrenia patients, like Saks and the member of the Voice Hearers’ Network, are aware of their condition. Awareness of illness and diagnosis has played a significant role in their responses to their condition. It has helped Saks to develop habits to manage her symptoms (e.g., reading Aristotle in the library, and taking her medications regularly) (Saks, 2007). It has led the member of the Voice Hearers’ Network seek help from other individuals with similar experiences as the shock treatments were not effective in addressing her problems (Hornstein, 2009).

Awareness of illness and diagnosis are also critical in clinical intervention (Tekin, 2010, 2011). For one, research indicates that, when the patient is aware of her condition, she tends to adhere to the treatment plan, including medication regimen, which may help her to alleviate some of the symptoms of her illness (Kikkert et al., 2006). In addition, there are a number of studies indicating that Cognitive Therapy, a form
of therapy that targets patient’s awareness of her condition, at least in the short term, is effective for overcoming some symptoms of schizophrenia, such as acute psychosis and delusional beliefs (Drury, Birchwood, & Cochrane, 1996). The procedure involves individual cognitive therapy, during which patients’ key delusional beliefs are identified and challenged with empirical evidence (Birchwood & Drury, 1995; Drury, 2000). The procedure also contains group cognitive therapy. Patients evaluate each others’ delusional beliefs so that they collectively notice the poor and contradictory evidence that support their beliefs. They then consider alternative justifications for these beliefs. Both in the individual and group cognitive therapy, increasing patients’ awareness of their delusions facilitate the reduction of their positive symptoms (hallucinations and delusions).

Thus, even though the properties of the members of a psychiatric kind (individuals with mental disorders) change owing to being aware of the illness and diagnosis—because they change their habits, and respond to psychotherapy, and medication regiments—the development of effective psychiatric intervention is not ruled out. In fact, what seems to cause difficulty in effectively treating schizophrenia is anosognosia, that is, the lack of illness awareness (leaving properties of schizophrenia stable), not its presence (making properties of schizophrenia unstable). Patients with anosognosia resist treatment with the following statement: “I’m not sick, I don’t need help” (Amador & Johanson, 2000). Some never accept medications or other forms of therapy; others stop taking their medications and refuse psychotherapy once they leave the hospital. Research inquiring into factors that contribute to the non-adherence to the treatment plan takes poor illness insight among the significant factors.

There are strategies developed to treat patients with anosognosia, however. According to one view, the wrong approach is to force patients to accept that they are ill (Amador and Johanson, 2000). Rather, the clinician, or the support worker, is encouraged to take the following four steps, also called LEAP strategy, in trying to develop a relationship with the patient: The clinician must Listen to the patient, Empathize with her experiences and complaints (not wanting to stay in the hospital, for instance, because she is not sick), Agree with the points she makes, and Partner with her. This way, the clinician builds a trusting relationship with the patient and is able to intervene in helpful ways.

To be clear: my argument is not that illness awareness is always necessary for improving the patient’s condition. As stated, many examples illustrate that awareness of illness can contribute to the improvement of a patient’s conditions; an equal number of examples illustrate the opposite. Nor do I suggest that it is always easy to figure out when the patient has anosognosia and when she is simply disagreeing with her therapist. I am arguing that there are strategies for successfully treating schizophrenia in both cases: that is, when patients are aware of their labels (as in the case of Elyn Saks and the Voice Hearer) and when the patients are not aware of their labels (the anosognosia examples). The point of the discussion here is that instability of the kind, due to looping effects stemming from ‘awareness’ of the illness is not always an obstacle for developing successful interventions, a presupposition that remained unexamined in the Looping debate. The point of bringing forward the scientific, clinical, and first-person data via the trilateral strategy is to show the complexity of the relationship between illness awareness and mental illness, something left unexamined by those using the comparative strategy.

Self-Concepts and Schizophrenia

Consider a second important parameter of the phenomenon of looping effects, namely, changes in the subject’s self-concepts upon being identified as belonging to a human kind. Challenging the assumption of the participants of the Looping Debate, the trilateral strategy shows that self-concepts do not necessarily change after being diagnosed with schizophrenia. There is empirical evidence that shows us the myriad ways in which schizophrenia patients’ self-concepts alter; there are also several examples that reveal that their self-concepts remain intact.

It is necessary to define self-concept, something ignored by the proponents of the LA and the PA (Tekin, 2014). Self-concepts are schematic sets of beliefs that store information about the individual.
They selectively represent the self to the self and to others (Jopling, 2000; Neisser, 1988). Self-concepts comprise somatic features, character traits, values, moral feelings, desires, and commitments that define the self. The information that grounds self-concepts originate from both the individual herself and from the physical and social environment she is embedded. Some examples include social self-concepts (e.g., being a friendly person), moral self-concepts (e.g., being a patient person), theological and metaphysical self-concepts (e.g., being a Buddhist), and somatic self-concepts (e.g., being a tall person) (Jopling, 2000). I focus on two types of self-concepts here that are relevant for schizophrenia, namely, self-concepts that originate from the individual’s encounter with illness (Neisser, 1998; Parnas, 2003; Parnas et al., 2005; Tekin, 2010, 2011, 2014), and self-concepts that originate from the narratives of individual’s illness (Flanagan, 1991, 1996; Frank, 1995; Jopling, 2000; Kleinman, 1988; Tekin, 2014).

The first source of alterations in the self-concepts of the individuals is their confrontation with schizophrenia, that is, patients’ conception of themselves changes under the influence of the illness. Some individuals with schizophrenia have distorted somatic self-concepts, for example, they conceive themselves as objects. This is due to their illness; they have a ‘diminished sense of self,’ including ‘a sense of inner void,’ ‘lack of inner nucleus,’ ‘a lack of identity,’ ‘feelings of being anonymous, as if non-existent or profoundly different from other people’ (Parnas, 2003; Sass & Parnas, 2003). One patient characterizes these experiences as a ‘sense of inferiority’; he feels that his ‘existence was as of a dispensable object, ... a thing, a refrigerator, and not a human subject’ (Parnas et al., 2005). Some of these patients are aware that their perceived reality does not respond to the actual states of affairs in the world, yet they conceive themselves in such ways. Thus, most of them are subject to competing self-concepts, for example, concepts of themselves as human beings, not objects, and the concepts of themselves as objects such as a table. Some other patients, however, those with anosognosia, are not aware that what they are encountering is the symptoms of their illness; thus, they really do believe that they are objects. Thus, their self-concepts as objects are more or less stable.

Another source of changes in self-concepts is delusions. For instance, some patients develop the belief that their friends and colleagues are spying on them and that they have plans to harm them in various ways. They report that they hear voices that signal these harms (e.g., Saks, 2007; Sass, 1994). These patients conceive themselves as victims. On the other hand, individuals with anosognosia have more or less stable self-concepts as persons subject to false treatment (as in the case where the patient claims that he was put in the mental hospital because there were no other beds available in the hospital). These examples illustrate that there are myriad ways in which individuals’ self-concepts may alter or may remain intact after being diagnosed with schizophrenia.

Another source of changes in self-concepts are the narratives about the individual’s illness. Illness narratives are the first-person or third-person stories that describe one’s encounter with illness, including its phenomenological features, the intersubjective challenges that are faced therein, the clinical diagnosis and the treatment the patient receives, the alterations in her social status after illness, as well as the folk conceptions of and the stigma around illness. They serve as sense-making tools that help to sculpt meaning from a bundle of un-narrated states of affairs pertaining to the sick person’s life. Consider the illness narratives shaped by the clinical diagnosis, and the ones informed by stigma.

One source of illness narratives that change individuals’ self-concepts is the clinical diagnosis. In addition to offering some methods of treatment for the patient, the diagnosis of mental disorder serve as an epistemic source for illness narratives (Tekin, 2010, 2011, 2014, 2015). The following first-person report from a schizophrenia patient describes his response to the clinical diagnosis:

I have been dealing with psychosis since about 2003, and have been diagnosed as schizophrenic. I have noticed a direct impact on my own thoughts of self, not only based on the disease, but also on how I think about the disease, and manage it, and learn about it. My doctor sometimes gets upset that I talk too much like a textbook, referring to some of the symptoms on a clini-
Here, the patient’s primary concern is that the scientific and clinical conceptualizations of schizophrenia fundamentally shape his illness encounter. Specifically, he seems to have become less inclined to rely on explanations that appeal to the qualitative and subjective features of his encounter with schizophrenia and more inclined to rely on the clinical explanations. This is not unique to this individual patient. Many patients with schizophrenia and other mental disorders are subject to such experiences, primarily because the diagnosis makes concrete some of the unfathomable and ambiguous experiences that are associated with illness and gives patients some kind of certainty about what happens to them (Tekin, 2010, 2011, 2015).

In patients with anosognosia, however, self-concepts may remain intact, because illness narratives are primarily confabulations, as in the case of the patient who reports that he is in the hospital because other beds in the hospital were full (Amador & Johanson, 2000). Still, it is plausible, however, to suggest that, because of the way the person is treated by others, the person may develop a self-concept as a victim of the lack of resources at the hospital, or as a victim of others’ judgment of him as a mentally ill person.

Another source of illness narratives that shape self-concepts is mental disorder stigma. Some individuals with schizophrenia, embedded in a culture steeped in stigmatizing images of schizophrenia, internalize stigma and develop self-concepts such as ‘dangerous,’ ‘unfit for work,’ or ‘someone to be avoided in relationships’ (Corrigan, Edwards, Green, Diwan, & Penn, 2001). Self-stigma may lead to impoverished self-esteem and self-efficacy (Corrigan & Nelson, 1998; Wahl, 1999). For instance, a patient writes:

I perceived myself, quite accurately unfortunately, as having a serious mental illness and therefore as having been relegated to what I called ‘the social garbage heap.’ … I tortured myself with the persistent and repetitive thought that people I would encounter, even total strangers, did not like me and wished that mentally ill people like me did not exist. (Gallo, 1994, pp. 407-408)

However, research from social psychology indicates that it is not always the case that stigma leads to self-stigma, diminished self-esteem, and self-efficacy. There are situational factors at play. Some individuals may lose self-esteem, if and when they perceive the stigma to be legitimate, whereas some are energized by stigma, and express righteous anger, if and when the person does not perceive stigma to be legitimate. And some individuals ignore the effects of stigma altogether (Corrigan & Watson, 2002). Thus, self-concepts that originate from stigma around schizophrenia may change in myriad ways or remain intact.

**Schizophrenia, Self-concepts, and Intervention**

The trilateral strategy shows that neither the absence nor the presence of the changes in self-concepts is an impediment to developing effective interventions in psychiatry—an important point that remained unsettled by the comparative strategy. That is, the instability of a psychiatric kind is not an impediment to intervention. Consider here two possible strategies to intervene on schizophrenia. The first is to take the alterations in self-concepts as early signs of schizophrenia, and clinically intervene at this stage. The second strategy involves working on the self-concepts of individuals to help alleviate their symptoms.

Some clinical research emphasizes the importance of intervening when the patient starts developing the symptoms of schizophrenia. The kinds of disorders in self-concepts, as the one discussed above where the patient feels as if she is an object, are considered to be a core feature and among the early symptoms of schizophrenia (Parnas & Handest, 2003; Sass & Parnas, 2003). Because at this stage the disorder is not yet entrenched, interventions are said to improve the longer term outcome of patients or even prevent the full development of illness (Yung et al., 2003). Some treatments include a low dose of antipsychotic medication, and cognitive therapy (Schaffner & McGorry, 2001).

The second strategy targets altering self-concepts in a way to induce positive changes in patients’ response to their illness. Self-concepts are not only representations of the self to the self but they also have instrumental role in guiding
individuals’ actions (Jopling, 2000; Neisser, 1988). Put otherwise, our ideas about ourselves inform how we behave. My self-concept of my physical strength affects my physical activities: I may or may not reach out to lift a suitcase depending on how strong I feel and how heavy I perceive the suitcase to be. Similarly, my self-concept about my intelligence and ability to learn new philosophical material influences what I can actually learn or how well I do in a job interview.

In the context of mental disorders, self-concepts that are guided by the individual’s illness narratives motivate the subject to think, act, and behave in certain ways, restricting or expanding her resources in responding to his illness (Jopling, 2000; Tekin, 2010, 2011). Saks and the member of the Voice Hearer’s Network discussed above are good illustrations of how conceiving one’s self as needing help enhances one’s ability to respond to schizophrenia, by adhering to the medication regimen, psychotherapy, and reaching out to others who encounter similar experiences.

There are also treatment methods, such as the Cognitive Therapy, which aim to help patients develop self-concepts that will guide them to improve their life notwithstanding their illness. For example, some forms of Cognitive Therapy target reducing patients’ self-stigma. Therapists teach individuals to recognize the relationship between their negative automatic thoughts (e.g., they are incompetent in finishing a task successfully because they have schizophrenia) and connected behaviors (e.g., giving up on the task). Then, individuals are encouraged to identify the underlying errors in their self-concepts and challenge them by reconsidering their self-related thoughts in a more balanced way (Dickerson, 2000). Confronting their false self-concepts and working on changing them enables patients to develop effective responses to their condition.

THE TRILATERAL STRATEGY AND OTHER MENTAL DISORDERS

One might ask if the trilateral approach can be generalized across other mental disorders. The answer is yes: it could be used to determine the properties of other mental disorders that are relevant for intervention. Consider post-traumatic stress disorder (PTSD), whose status as a ‘real’ disorder has been the topic of much philosophical contention (Zachar, 2014). Yet, its urgency to receive scientific, clinical, and political attention has been rarely contested, given the number of those suffering from post-traumatic stresses generated by sexual harassment, natural disasters, war, and so on. Using the trilateral strategy, philosophers can tap into three resources for identifying the properties of PTSD relevant for intervention: scientific and clinical work on individuals with PTSD, and first-person narratives. These sources would perhaps allow us to distinguish those cases of PTSD after rape from those after the Iraq war based on those features that have been instrumental for effective interventions. The comparative strategy, on the other hand, may block progress in finding the properties relevant for intervention in PTSD, primarily because comparing PTSD with chemical elements or biological species will not give us much information about the individuals suffering from PTSD. But, if the goal of the inquiry is arriving at properties relevant for explanation and prediction, as opposed to intervention, comparing PTSD with gold, for example, may be relevant. It would allow neuroscientists to work on identifying a basic mechanism that underlies PTSD.

CONCLUSION

This paper targets a strategy in philosophy of psychiatry literature, namely, comparing mental disorders with paradigmatic natural kinds to identify a set of properties that fulfills the purposes of explanation, prediction, and intervention. I show that the comparative strategy fails to take us to the intervention-related properties of mental disorders. I replace it with a trilateral strategy, guided by the first-person accounts of and the clinical and scientific work on individuals with psychopathology. Using the case of schizophrenia, I illustrate how the trilateral strategy works and conclude that, unless philosophers pay attention to actual clinical and scientific work on mental disorders as well as first-person accounts of those living with them, they cannot make a fruitful contribution to the development of successful interventions in psychiatry.
ACKNOWLEDGMENTS

The author thanks Edouard Machery, Clare Batty, Muhammad Ali Khalidi, Kenneth Schaffner, Kathryn Tabb, Kyle Stanford, Owen Flanagan, and George Graham for their invaluable feedback on this work. I am also grateful for the insightful comments from my colleagues at the Center for Philosophy of Science at University of Pittsburgh, my fellow mentees at The Mentoring Project For Pre-tenure Women Faculty in Philosophy at University of Massachusetts, Amherst, and the audience members at George Washington University, Dalhousie University, and Bogazici University.

NOTES

1. According to a World Health Organization report (2007), the global burden of mental health disease will increase from 10.5% in 1990 to 14.7% in 2020.

2. Some philosophers argue for or against the claim that mental disorders are natural kinds; others focus on a specific symptom of a mental disorder, for example, delusions, and consider whether they are natural kinds. Both claims make the presumptions that this paper targets.

3. Following the terminology in the relevant literature, I use ‘category of mental disorder’ interchangeably with ‘mental disorder,’ and ‘psychiatric kind.’

4. Others have offered excellent overviews of the competing approaches to natural kinds in metaphysics and philosophy of science literature (Cooper, 2004a, 2005, 2007; Zachar, 2000; Machery, 2009; Samuels, 2009; Khalidi, 2010; Zachar, 2014). I shall not repeat them here.

5. Hacking, in his later work, abandons the notion of natural kinds (Hacking 2007). I limit myself to his earlier views in this article.

6. Hacking’s inconsistency in discussing the parameters of looping effects results with the PA proponents’ neglect of the alterations in self-concepts while assessing whether natural kinds are also subject to looping effects. See Tekin (2014) for the full development of this argument.

7. Hacking thinks that looping effects make it hard, if not impossible, to study mental disorders and other social phenomena, since they’re moving targets. Ron Mallon (2003) challenges Hacking on this point.

8. For instance, according to one view defended by PA proponents, microbes adapt themselves to the attempts to eradicate them (Douglas, 1986, pp. 100–102). Based on the classification of microbes as harmful, those so infected receive antibacterial medications. In response, microbes resist the medications and mutate.

Hacking writes in response to Douglas: “My simple-minded reply is that microbes do not do all these things because, either individually or collectively, they are aware of what we are doing to them. The classification microbe is indifferent, not interactive, although we are certainly not indifferent to microbes, and they do interact with us. But not because they know what they are doing” (Hacking, 1999, p. 106; emphasis mine). Another view argues that classifying marijuana as illegal leads to changes in the shape of marijuana (Bogen, 1988). In yet another view, selective breeding after classifying some animals as ‘Best in Show’ leads to changes in animal kinds (Cooper, 2004a, 2004b, 2007; Khalidi, 2010). Finally, the domestication of dogs is put forward as another example of looping effects in natural kinds, as human interventions, over time, lead to changes in the kinds of dogs (Khalidi, 2010). For a detailed treatment of this historical debate and Hacking’s responses to the proponents of PA, see (Tekin, 2014).

9. Hacking is arguably an exception to this charge because he investigates conditions like the multiple personality disorders fugue and autism, and based on these case studies he argues that instability in mental disorders is common. However, such close examination is limited to these conditions, and there is no explicit discussion on properties of mental disorders that are relevant for intervention. In an example like schizophrenia, as cited, he wrongly assumes that individuals with schizophrenia are subject to awareness, but as discussed in the third section, this is not necessarily the case. As I show, using the trilateral strategy, being subject to looping effects is not a generalizable future of mental disorders.

10. For instance, Hacking, supporting LA, discusses how looping effects come about in schizophrenia and why this condition is not a natural kind but an interactive kind (Hacking, 1999, pp. 100–114). He highlights awareness and alterations of self-concepts as the main generators of looping effects in schizophrenia:

Here I am concerned with kinds of people, their behavior, and their experiences involving action, awareness, agency, and self-awareness. The awareness may be personal, but more commonly is an awareness shared and developed within a group of people, embedded in practices and institutions... We are especially concerned with classifications that, when known by people or by those around them, and put to work in institutions, change the ways in which individuals experience themselves—and may even lead people to evolve their feelings and behavior in part because they are so classified. Such kinds (of people a their behavior) are interactive kinds ... take schizophrenia ... We need not embrace anti-psychiatry to realize that the classification as schizophrenic, and current attitudes to and treatments of schizophrenics, are matters of which the patients, for
all their periodic deficits of logic and sense of reality, are intensely aware. More of them are more aware now than they used to be ... The schizophrenic, as a kind of person, is a moving target, and the classification is an interactive kind. (Hacking, 1999, pp. 106–114).

Cooper, in her argument for the claim that mental disorders are natural kinds, also uses schizophrenia as an example.

Many authors writing about kinds have worried about whether our classifications cut nature “at the joints”. On my account of natural kinds seeing the problem primarily in these terms is something of a red herring. The key worry is whether our classifications group together entities that are genuinely similar to each other ... [W]e should primarily worry whether categories, such as “schizophrenia”, group together cases that are actually similar to each other at a fundamental level, or whether we are lumping together cases that are fundamentally radically different. If schizophrenia fades into some category, such as schizotypal personality disorder, then it will, of course, be as well to know this, but so long as cases of schizophrenia are fundamentally similar, schizophrenia is still a natural kind on my account. Even if schizophrenia fails to be discrete, knowing that someone suffers from schizophrenia could still be used as the basis of inductive inferences and function as an explanation. (Cooper, 2005, pp. 73–74)

Similarly, Samuels (2009), taking delusions among the symptoms of schizophrenia, considers delusions as possible candidates for natural kinds.

11. Note that I am in agreement with the proponents of LA in their suggestion that instability owing to looping is an impediment for research. What I suggest, different from them, is that whereas the instability may be an impediment for research, it is not necessarily an impediment for intervention. In fact, depending on whether the patient is aware or unaware of the label, different intervention strategies can be used—this is the point of the two examples I consider, where patient is aware of the label (e.g., Saks), and where the patient is unaware of the label (e.g., cases of anosognosia). My contribution to literature here, different from the proponents of LA, is to distinguish what is needed for research purposes from what is needed for intervention purposes.

12. It is ambiguous in Hacking’s account whether awareness of the illness, or the awareness of the diagnosis, is required for the generation of looping effects. I consider both of these elements, because the patient’s response to diagnosis and her response to the illness itself are not readily distinguishable from each other when the patient’s first-person experience is considered. In addition, they are both important for intervention in psychiatry, and thus fit the purposes of this paper.

13. The self is a dynamic, complex, relational, multi-aspectual, and more or less integrated configuration of capacities, processes, states, and traits, which support a degree of agential capacity subject to various psychopathologies (Jopling, 2000; Neisser, 1998; Tekin, 2014). The aspects of the self are the ecological, intersubjective, temporal, private, and the conceptual dimensions. Self-concepts are formed by the information received from the aspects of the self, as well as from the physical and social environment. Here, I focus primarily on self-concepts that originate from the subject’s illness encounter, and illness narratives.

REFERENCES


