

5-1-2013

Diagnostic Interaction: First-Person Patient Narratives on Hacking's Looping Effects and the Normative Status of Psychiatric Nosology

Corinne Jager

University of Massachusetts Boston

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Recommended Citation

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Corinne Jager
PHIL 489 – Independent Study
Danielle Bromwich, Advisor
Senior Honors thesis
20 May 2013

Diagnostic interaction:

First-person patient narratives on Hacking's looping effects
and the normative status of psychiatric nosology

Introduction:

What is the interaction between a psychiatric patient and their diagnosis? How do they respond to being classified? A number of philosophical theories attempt to explain the interaction between the diagnosed patient and their classification. Ian Hacking develops an account of interaction which holds that objects of human science classification are influenced by the awareness of the classification in a way that changes both the classification and its object. Hacking thinks that psychiatric patients are “interactive kinds” whose awareness of their classification causes changes in the individuals' experience of themselves, and thus changes in their classification. Hacking claims that these “looping effects” destabilize the classifications and their objects, and make them “moving targets.” But Jonathan Tsou responds to Hacking with the claim that many objects are less subject to looping effects than Hacking thinks. Tsou attributes this stability to most classifications' grounding in biological ubiquities.

Theories of interaction must account for the lived experience of these objects of classification. The narratives of psychiatric patients provide opportunities to test Hacking's and Tsou's versions of looping effects theory. These written first-person narratives were found in public sources on the internet. A broad review of psychiatric patient writing revealed that most patient narratives fell into one of two categories, “true believers” or “skeptics,” distinguished by the patients' perceived beliefs about

the legitimacy of their diagnosis.

The “true believer” phenomenon is represented in the narrative of Woodrow Odom Lucas, age 36, whose diagnosis is schizoaffective disorder. Lucas' writing was found on the New York Times “Patient Voices” blog (“Patient Voices: Schizophrenia”):

“The first time I began having symptoms of schizoaffective disorder was in 1999. I started to hear strange voices, not just comforting or guiding internal intuitions, but voices telling me that I was the spawn of Satan, or voices telling me that I was about to come under judgment...I really began to believe those voices. I experienced acute psychosis, which I thought at the time was a demon inside of my trying to take over my mind. Schizoaffective disorder is like a cross between bipolar and schizophrenia. The psychosis side and the delusion side is much less severe than schizophrenia but more severe than bipolar II. The mood swings in my opinion may be a little less severe than certain dimensions of bipolar so it's like worse than bipolar, better than schizophrenia, and a mixture of the two.

In the beginning, it was horrific. I had a lot of ambition...all of this was shattered. My efficacy as a father was virtually gone. I felt like I had no love for my wife or anyone in the beginning months. I was extremely depressed, morose and disconnected. I think I've got a long way to go, but throughout it, because of the love of God and people, it's been a journey of hope.”

The orientation of the skeptic is demonstrated in Leah Harris' writing. Harris, writing as an adult, was a teenage mental health patient. Her writing was found on the “Beyond Meds – Alternatives to Psychiatry” blog (“Decolonizing our minds, freeing our spirits: Guest blogger Leah Harris”):

“I had just been released from yet another hospital for a half-hearted suicide attempt... I had alternately fought and reluctantly accepted a view of myself as “sick” and “disordered.” I hated the labels but identified with them at the same time...I had no tools, no frameworks, with which to redraw the maps in my mind... But slowly, I discovered that I could work with voices...I have gotten feedback from many people that when they got a psychiatric label, it was a relief because it gave a name to what they had been experiencing. I don't discount the importance of a framework to make sense of our experiences, but who wants to be defined by a so-called illness?

I have found great validation...not from any psychiatric label but from friends in and out of the “mad movement.” We see how various institutions and oppressions are connected...It matters not if we are “well” or “ill,” “normal,” or “disordered.” I see our movement as... stealing back truths from industries that would have us only consume what they produce, whether it's ways of viewing ourselves or specific “treatments.” They would have us believe that we are so “sick” that we don't know what's in our own best interest, and we resist that determination with all our might. We are teaching each other how to get free.”

Patient narratives reveal a phenomenon which Hacking's looping effects theory does not account for, and which Jonathan Tsou cites in his response. Narratives show that patients who are true believers or skeptics are less “on the move” than Hacking thinks. True believers identify so thoroughly with their diagnosis that they “buy in” to its explanation for their experience, loop in the direction of their diagnosis, and stabilize. Skeptics reject diagnosis and psychiatric nosology in general and refuse to interact with their classifications; their rejection makes themselves outliers, not subject to looping effects and stabilized outside nosology. The narratives of both of these groups provide evidence to support Tsou's claim that Hacking is wrong about the extreme destabilization of psychiatric patients and their diagnosis. But they also call attention to something which neither Hacking nor Tsou account for: that patients' perception of the scientific and normative status of psychiatric nosology is a variable that affects the way they interact with and respond to diagnosis.

By normative, I mean that nosology is shaped by human judgment about what is good, healthy or “normal species functioning,” and that the categories are conjectural, designed for human use, and may not reflect deeper truths or “nature carved at its joints.” The normative status of human science nosology is widely accepted by the scientific community, but little work has examined patients' interaction with normativity.

The claim that patients' acceptance or rejection of the scientific legitimacy of psychiatric classification may affect their response to diagnosis is the novel contribution of this paper to the discussion about patient interaction. The essential distinction between “true believers” and “skeptics” is their beliefs about the normative status of psychiatry. It is the rigidity of their beliefs in either direction that explains how they become stable objects amidst Hacking's moving targets.

This paper begins by defining how all scientific classification schemes are inherently normative. A brief review of the evolution of the concept of mental illness, the psychiatric institution, and the formulation of current psychiatric nosology developed in the *Diagnostic and Statistical Manual of*

Mental Disorders shows the normative terrain of nosology, and suggests some aspects of normativity that may be problematic. Next, the paper will discuss the “DSM culture” created by the DSM's monopoly over the mental health system, which legitimizes existing nosology while construing the constructed-ness of the classifications themselves. Its medical explanation is framed as the powerful, ubiquitous “master narrative,” which further construes the normative status of the nosology it represents. Next, the paper will offer a detailed account of Hacking's and Tsou's theories on looping effects. Then, it will analyze the patient narratives to show how they support Tsou's claim that Hacking is mistaken about the unstable status of objects of human science classification. Finally, it will claim that what we can infer about awareness of the master narrative in the skeptics' and true believers' writing suggests that patients' ideas about the normative status of scientific nosology may affect the way they respond to classification. I submit that patients' beliefs about the normative status of scientific classification schemes, and psychiatric nosology specifically, influence the way patients interact with diagnosis.

I. The normative status of human science nosology

It is widely accepted in the scientific, medical and philosophical community that scientific classification schemes have normative status. By normative, I mean that classification schemes are designed with reference to an ideal of good health or “normal species functioning” (Sillers, 64). Normative statements make claims about what is good or bad, or how the world ought to be.

All disease classification schemes are inherently normative because judgment goes into establishing what we consider to good, normal or healthy, and what we, conversely, consider disordered. This notion is captured in the evaluativism-objectivism conceptual dimension of classification as described by Peter Zachar and Kenneth Kendler in their article “Psychiatric Disorders: A Conceptual Taxonomy.” The objectivism–evaluativism dimension asks the question, “is deciding

whether something is a disorder a simple factual matter, or a value-laden judgment (Kendler and Zachar, 558)?” Evaluativism is a rejection of the idea that those things which are considered mental illness are determined through purely objective means. Kendler holds that objectivism depends on the idea of “natural function;” that is, if something breaks, we can fix it without judgment about how it ought to function. But evaluativists dismiss objectivism, saying that what counts as dysfunction inevitably entails this judgment. Bioethicist Norman Daniels offers a response to this tension with his concept of “normal species functioning.” Daniels says that diseases are deviation from the natural functional organization of a typical member of the species, and that we have an objective interest in identifying disease consistently in order to maintain a normal range of opportunity for all members of the species (Silvers, 64). At their ideal, our disease classification schemes are formed using judgment that has an interest in maintaining equal opportunity for all.

Another aspect of the normativity of nosology is its conjectural status – that our existing classification schemes are our best attempt at mapping disorder, but may not represent “nature carved at its joints.” This aspect of nosology is developed in the nominalism-essentialism dimension laid out by Kendler and Zachar. This dimension asks the question, do we believe that we can uncover a classification scheme in which categories are determined by their “underlying nature,” or do we define our categories practically, for the purposes of human use (Zachar and Kendler, 558)? The phrase “carving nature at its joints,” coined by the early Greeks, has been frequently used to reflect the phenomenon of essentialism. Essentialists believe that nature can be carved at its joints to reveal classifications distinguished by their causal and biological ubiquity, and that it is the task of nosologists to identify and classify them accurately; successful essentialism in the natural sciences, such as chemistry, has led to the identification of elements such as gold or oxygen as “natural kinds” (Zachar and Kendler, 558). Nominalists, however, maintain that there is ambiguity about whether our nosology can reflect deeper truths about the world or “carve nature at its joints.” Whether or not disorders exist

as “natural kinds” in the world, we must recognize that there is no best way for classifying them, and that, therefore, nosologists must use some judgment as to which factors should be highlighted and minimized when designing nosology (Zachar and Kendler, 558). The scientific community's awareness that nosology may not correspond to universals is critical for an awareness of its normativity.

The normativity inherent to nosology as well as its problematic aspects can be further articulated by noting the difference between statistical norms and norms as prescriptive ideals, as standards. Ideally, nosology would capture statistically abnormal states in order to, as Daniels suggests, restore opportunity to their species (Silvers, 64). But many norms are prescriptive because they reinforce an ideal as a norm. One useful example of the different functions of norms is the norm of two legs – a condition which is statistically normative among humans, but becomes prescriptive when we structure our physical space to be navigated in ways that give preference to it. If nosology reflects prescriptive ideals not backed by statistical norms, it suggests the problematic aspects of normativity.

The scientific community acknowledges that our values play a role in shaping classification schemes, and despite our best efforts at objectively deciding what constitutes disease or isolating “natural kinds,” nosology may be influenced by existing social norms or power structures (Foucault, xi). They also note that values shape what gets prioritized and discovered in scientific research (Cooper, “Classifying...,” 4). Critical interaction with nosology requires awareness that our classifications are conjectural and reflect our norms and values.

II. The evolution of the concept of mental illness, the psychiatric institution, and psychiatric nosology

An examination of the history of any science will demonstrate that normativity is inherent to the development of its classification scheme. History also shows the role of prescriptive ideals in shaping the problematic normative aspects of nosology. Michel Foucault's history of Western societies' construction of the paradigm of madness in the 15th century shows the distance between the

establishment of the concept of mental illness and its formulation into concise scientific nosology today.

Foucault's account of history is laden with an awareness of the role of social power in creating and establishing norms. In his book, *Madness and Civilization*, Foucault writes that the need to rid society of undesirables, and the need for cheap labor, motivated an increase in people considered mad by society; these first “mad” people had nothing to do with science. After epidemics of leprosy receded in the 15th century, “madmen” who had previously been driven beyond city walls were confined in leper hospitals, where they became subjects of the state (Foucault, 42). Later, thought that the source of their disorder was sin and idleness, these mad people confined in hospitals were made to do cheap labor as “penance and redemption” (Foucault, 54). Madness became increasingly criminalized, mad people were objects of animalistic exhibition, and an objective conception of the constitution of madness began to develop (Foucault, 69). At the turn of the eighteenth century, medical facilities for the mentally ill took on the role of curing society's mad (Foucault, 85). A theory of psychology dominated by Freudian psychoanalysis emerged. The incorporation of mental illness into a burgeoning, increasingly organized health care system in the United States led to the first attempt at a comprehensive nosology in 1952. The Diagnostic and Statistical Manual of Mental Disorders – I and II (1968) were uncontroversially based in psychoanalysis' theory of inner conflict (Kawa & Giordano, 3).

This account shows the problematic aspects of normativity in early attempts to classify the mad. Psychiatric nosology has its history in prescriptive ideals and designs for social control, and though the nosology has developed in an direction which is increasingly conscious of its normative status, problematic normative aspects are still at play.

The DSM-III (1980) represented a “revolutionary,” paradigmatic shift in psychiatric classification and the scientific status of psychiatry. In response to anti-psychiatrists who claimed that mental illness is socially constructed, the DSM-III represented psychiatry's aspiration to an increasingly

objective nosology by way of scientific scrupulosity (Kawa & Giordano, 5). From psychoanalytic Freudian states of “neurosis” to discrete disease categories including “neurotic disorder,” the DSM-III was seen as a “victory of science over ideology” and was the impetus for new research concerning drug treatment for and epidemiological investigations of DSM-III disorders (Kawa & Giordano, 5).

The medicalizing trend of the DSM-III is evidenced in the subsequent DSM-III-R, DSM-IV, DSM-IV-TR and DSM-V (slated for release in summer 20130). These versions include increased data on prevalence, expanded sub-types for disorders, and “culture-bound syndromes” – an acknowledgement of the cultural variations in presentation and prevalence of disorders (Kawa & Giordano, 6). DSM-V is expected to cite increased biological, genetic and neurological findings, and specify how this information can be employed in diagnosis and treatment (Kawa & Giordano, 6).

The DSM and the nosological community have made great strides against the problematic aspects of normative judgments simply by becoming self-aware. The perspective to reflect on nosology as a mechanism for social control, by pathologizing socially undesirable behaviors or medicating social ills, has dismissed the nosology's most overtly evaluativist claims. And increased research efforts to develop classifications based on biological regularities are a powerful contribution to the ideal of an objective nosology. Still, psychiatric nosology remains powerfully normative. The patient narratives examined later in this paper suggest that true believers' and skeptics' interactions with diagnosis may have been influenced by varying awareness of the history of psychiatry, and of its normative status.

III. DSM culture's monopoly and the master narrative

Today, the DSM has a monopoly on defining mental disorders, and is the dominant (and often sole) lens through which it is interacted with and understood. Two philosophers examined later in this paper, Ian Hacking and Serife Tekin, cite the DSM's multi-focal monopoly over the mental health system as explanation for the DSM's dominant culture and how its nosology is represented without

implication of its normative status (Tekin, *Self-Insight*, IV; Hacking, "Making Up People," 2).

Today, the DSM serves as the centralized, universal manual for all parties concerned with mental disorders. It is the gospel for diagnosis and further psychiatric research; it also a tool for the legal, insurance and pharmaceutical purposes. Some worry that pressure from pharmaceutical lobbyists to raise the "prominence" of a condition so that their drugs will be more widely used hinders an accurate nosology (Tsou, "The Importance of History...", 448). Others note how pressure to appeal to funders and government endorsement might skew a research agenda (Kawa & Giordano, 6). Further, if doctors diagnose with the motivation of getting reimbursement for patients based on the severity of the coded diagnosis, will this shift the stringency of "what counts" in the DSM (Tsou, "The Importance of History...", 450)?

And the comprehensive DSM culture has generated problems for how mental illnesses are understood in society. Psychiatry has seen an increase in psycho-pharmaceutical interventions, while efficacious drugs for some disorders do not exist, and there is potential for abuse in this realm (Kawa & Giordano, 8). Further, there are concerns about disease mongering and the interpretation of subjective variables as diagnosable disorders. According to Kawa & Giordano, half of Americans will meet the qualifications for some disease in the DSM in their lifetime. Does the DSM pathologize behaviors such as shyness, medicalize social ills and deviance, or make authoritative claims about what constitutes normal in society (Kawa & Giordano, 9)? These issues all raise questions about how a psychiatric patient might respond to diagnosis with this awareness.

Yet a more essential concern about the financial and pharmaceutical pressures on the DSM is whether these demands distract from the scientific agenda of identifying essential "natural kinds," the underlying natural organization of categories independent from human involvement (Tsou, "The Importance of History...", 2; Kendler & Zachar, 558). Some worry that the DSM cannot meet all the extra-scientific demands leveled at it; others have concern that the DSM "distorts the status of current

knowledge about mental disorders” by disseminating presumed (expert-refined and institutionally-taught) knowledge as “fact” (Tekin, *Self-Insight*, IV; Hacking, “Making Up People,” 2). Again, the status of their relationship to these concerns may shape the experience of diagnosis for psychiatry patients.

These issues are linked to the difficulties of formulating nosology: existing classifications legitimize named diseases, while construing the constructed-ness of the categories themselves. This constructed-ness is further construed by the framing of the medical narrative as the “master narrative,” claims Jennifer Radden in her article “Recognition rights, mental health consumers and reconstructive cultural semantics.” Radden suggests that the master narrative is an expression of the power of a dominant group; in the case of psychiatric diagnosis, “telling it medically is taken as telling it 'how it is.’” The medical narrative is purported as objective, and the nosology it references a depiction of “nature carved at its joints.” It is so powerful that it denies alternative narratives their “vitality and even intelligibility” (Radden). But for all its ubiquity, the history of psychiatry will remind us that the medical framing of mental disorder was itself once a counter-story. Psychiatric nosology's normativity is construed by a dominant DSM culture and a medical master narrative which deny how values and power have shaped its origins.

Awareness of the normativity of nosology and its role as master narrative is critical to our interaction with it. We should presume that the scientific community interacts with the taxonomies it develops with heavy nominalist sensibilities, but among laypeople, the notion that a scientific classification scheme is not or does not believe itself to be essentialist may be the cause of misconception about the 'realness' and experience of the diagnosis, and its implications. The misimpression that diagnoses represent disorders which are bonafide “natural kinds” or pieces of “nature carved at its joints,” especially in dominant forms such as the master narrative purported by authoritative experts and institutions, may cause its conjectural and normative nature to be overlooked.

Varying levels of awareness of normativity are demonstrated in patients' written narratives, and seem to play a role in the patients' interaction with their classification. This awareness may differently shape the expectations for, experience of, and reaction to diagnosis for each patient, and should be seriously considered in the way experts represent and convey scientific knowledge.

IV. Hacking and Tsou on looping effects

Given that psychiatric nosology and the DSM culture in which it is delivered are normative, two interesting questions are, how do patients interact with their classification or diagnosis? And, how do they do so in light of this normativity? I intend to examine patients' firsthand, written narratives to see what interaction looks like, and whether any cognizance of normativity that I refer to can be detected to analyze its effects on patient interaction with diagnosis. Do patients reflect on their diagnosis with awareness that the ideal objectivity of psychiatric classifications is inherently normative, or suggest belief in the universalizability of their diagnosis, that it is a component of “nature carved at its joints?”

Ian Hacking's looping effects theory, later refined by Jonathan Tsou, is the most, relevant prominent response to the question of how the diagnosed interact with the diagnosis. In the following pages, I will lay out Hacking's theory, and Tsou's response to it, before examining whether it has explanatory power for the diagnostic experience reflected in the patient narratives, or accounts for an awareness of normativity. Tsou's response better accounts for the patient experience evidenced in the narratives, but neither Hacking nor Tsou consider the effect of patients' beliefs about the normative status of nosology in their theory of interaction.

To develop his theory of looping effects, Hacking challenges the common idea that people are solid objects of human science inquiry which can be grouped into definite classes by definite properties (Hacking, “Making Up People,” 1). He thinks that nosology is dynamic – in his words, the “names interact with the named” (Hacking, “Making...” 1). Hacking suggests a new way to conceive of objects

of classification that considers whether the classified are shaped by awareness of the classification. He calls the components “indifferent kinds” and “interactive kinds” (Hacking, “Madness...,” 101).

Interactive kinds are those for which awareness of classification affects the experience of it. These classifications, “when known by people or 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” (Hacking, “Madness...,” 104). What was known about interactive kinds may become false because the people of that group have changed in virtue of how they have been classified, what they believe about themselves, or because of how they have been treated as so classified (Hacking, “Madness...,” 104). This change is a looping effect.

One way to imagine the looping effect is using Hacking's example of Multiple Personality Disorder. In 1970, some psychiatrists began to diagnose MPD; people increasingly came forward, presenting the symptoms for the disorder (Hacking, “Making Up People,” 2). Quickly, the mean number of personalities rose from two to seventeen. Psychiatrists used this feedback to update the diagnosis, and therapists anticipated a high number of personalities (Hacking, “Making Up People,” 2). Moreover, a Freudian theory of early sexual abuse was put forward to explain the disorder, and patients obligingly produced the memories (Hacking, “Making Up People,” 2). Hacking argues that, before the diagnosis, for example in 1955, MPD wasn't an identity for a person or which one's family, friends, counselors and world could interact with; but in 1985, after the diagnosis was well-established, MPD was “a way to be a person, to experience oneself, to live in society” (Hacking, “Making Up People,” 3).

This feedback between the diagnosis and the diagnosed is what Hacking identifies as the looping effect. An increased manifestation of symptoms led to a revision of the standard diagnosis and explanation, and patients presented symptoms according to the new framework put forth by experts. But Hacking thinks that the cycle of looping persists beyond a single revision of the diagnosis; “our interactions [continue to] change them” and the target moves (Hacking, “Making Up People,” 2).

Hacking distinguishes indifferent from interactive kinds because awareness does not change or make a difference to them; they are not subject to looping effects. Indifferent kinds are characterized by an assumed fixed underlying biological, neurological or genetic ubiquity. This biological “indifference” is an assumed aspect of “natural kinds;” natural kinds are thought to be the elementally isolated objects such as gold, oxygen, lemon and horses (Hacking, “Madness...,” 107).

Hacking asserts that the classifications employed in the human sciences are mostly interactive kinds, subject to looping effects. About classified people, Hacking writes, “they are moving targets because our investigations interact with them, and change them. And since they are changed, they are not the same kind of people as they were before. The target has moved. I call this the ‘looping effect.’” (Hacking, “Making Up People,” 1). Hacking's claims have big implications for how we should expect psychiatric patients to relate to their diagnoses.

Jonathan Tsou responses to Hacking set the stage for this paper's investigation of whether Hacking's theory can explain the phenomenon in psychiatric patients' narratives of diagnosis. Tsou's analysis supports his critical claim that objects of psychiatric classification – and objects of human science classification in general – are less subject to strong looping effects, and that they may be more stable than the moving targets that Hacking imagines them to be. Tsou's response is a more accurate representation of the interaction demonstrated in the patient narratives examined in this paper. Still, neither Tsou nor Hacking seem to account for the effect of patients' awareness of normativity on the interaction with their diagnosis.

In his response, Tsou first questions whether Hacking's “kinds” refer to classifications or objects. He points to Hacking's fuzziness in defining indifferent kinds: he refers to them as “classifications without looping effects” in contrast to interactive kinds, but also as referencing a “stereotypical biological abnormality” (Tsou, “Hacking...,” 332) (Hacking, “Madness...,” 104). The first reference suggests that interactive kinds are mutually exclusive to indifferent kinds, based on the

presence of a looping effect (Tsou, “Hacking...,” 334). But Hacking also suggests that some human kinds are both interactive and indifferent kinds (Tsou, “Hacking...,” 334) (Hacking, “Madness...,” 115). Tsou holds that Hacking cannot then claim that looping effects are the sole criteria for distinguishing between kinds (Tsou, “Hacking...,” 334).

This inconsistency is helpful for Tsou to posit that “kinds” refer to classified objects. He holds that, though Hacking claims to be talking about kinds as classifications, his suggestion that they depend on the presence of a “biological pathway” implies that they more adequately refer to objects of classification (as the classifications cannot have biological pathways) (Tsou, “Hacking...,” 335).

The more significant contribution of Tsou to Hacking's argument and to the argument that will be developed in this paper is a refreshed distinction between indifferent and interactive kinds of objects of classification. He holds that objects of human science classification can – and do – have both indifferent and interactive aspects! Tsou thinks indifferent kinds are characterized by “a clear and predictable biological basis” for mental disorder, regardless of looping effects (Tsou, “Hacking...,” 336). Like Hacking, Tsou takes the “biological regularities” evidenced in current research for schizophrenia and depression “to count...for the reality of these conditions, and indicate the way in which such conditions approach the traditional idea of 'natural kinds'” (Tsou, “Hacking...,” 337). What distinguishes indifferent kinds is the law-like presence of these regularities, and not that the classifications of these conditions will be void of looping effects.

It is objects' awareness of the classification that characterize Tsou's interactive kinds (Tsou, “Hacking...,” 337). Tsou points out that one would expect all objects of human science classification to have this characteristic, to varying degrees, based on how directly aware they are of their classification (Tsou, “Hacking...,” 338). Autistic children, for example, are likely to be less aware of their classification than would anxious adults.

Tsou uses this new distinction to dismantle Hacking's idea that because of the persistently

dynamic relationship between human science classifications and objects, the kinds of people being classified are “on the move,” with the implication that there is “no stable object to study” (Tsou, “Hacking...,” 338). Tsou smartly contends that objects of human science classification are interactive *and* indifferent kinds, and that their indifferent aspects can be understood as exerting a stabilizing force which makes them not subject to looping effects; moreover, he thinks that Hacking's claim that classifications with indifferent aspects are rendered unstable by their looping effects is a failure to distinguish between the implications of strong and weak looping effects. Tsou's account of looping effects better explains the phenomenon in the patient narratives.

IV. Do narratives reflect the theory?

Tsou's responses held that Hacking does not provide enough evidence to substantiate his claim that, because of looping effects, objects of human science classification are “on the move” – or “moving targets” (Hacking, “Madness...,” 109). Hacking's claim, Tsou maintains, results from a conflation of weak and strong looping effects, and a lack of acknowledgement of the stabilizing effect that the indifferent aspects of interactive/indifferent kinds have on objects of classification. Because most interactive kinds also have indifferent aspects, Tsou submits, they are much more stable than Hacking suggests.

A reasonable expectation for any theory is that it would explain the phenomenon. I want to understand the patient's (the object of classification's) perspective on interaction, and decided to look into written patient narratives of the experience of diagnosis (classification) to see if and how looping effects, as presented by Hacking and refined by Tsou, were evidenced. Below, I demonstrate how patient narratives confirm Tsou's claims: that Hacking mistakenly conflates strong and weak looping effects; and that most objects of classification are less moving targets subject to less strong looping effects than Hacking thinks, because their indifferent aspects (biological regularities) have stabilizing

force. Moreover, the patient narratives demonstrate that there is reason to think that patients' beliefs about the normativity of psychiatric classification and the DSM affect the way they experience and interact with their diagnosis. This is an aspect of looping effects – which has implications for the stability of moving targets – not accounted for by Hacking or Tsou.

I limited my search for patients' reflections on diagnosis (which I might use to detect evidence of looping effects and stability, and awareness of the classifications' normativity) to short narratives available to the public on the internet. I found that most of the first-hand writing available was either self-published in forum-style locations (where mental illness was the topic) or was presented as testimonial on a mental health advocacy website that somehow reflected the values of that organization. The forums featuring personal stories ranged from the New York Times Patient Voices blog, which interviews patients about their experience of disorders by classification, to the Experience Project, a place for “true stories shared by real people,” to Half of Us, an MTV-sponsored project which aims to raise awareness of the prevalence of mental illness among young people. The organizations included the National Alliance on Mental Illness, the national support network for mental illness care, Rethink, a organization devoted to challenging mental illness stigma, and MindFreedom International, a psychiatric survivors movement. The vast majority of the narratives I encountered could be easily separated into two distinct groups based on whether the patients' writing about their experience of diagnosis suggested they were amenable to the DSM master narrative. For my analysis, I decided to select one narrative representing each of the groups which epitomizes the characteristics unique to that group. Previewed for the reader in the introduction of this paper, Woodrow Odom Lucas' narrative represents the “true believer” phenomenon, while Leah Harris represents the “skeptics.”

It is important to note that all of the narratives found on the internet and examined to test for the explanatory power of the theory are not a perfect cross section of stories of the experience of mental disorder diagnosis. These written, publicly available narratives are self-selecting by their authors'

literacy and access to the internet; more importantly, these narratives are self-selecting based on their authors' desire to discuss their experience. In any type of survey that requires the participants' initiative, there is an overrepresentation of those participants who feel strongly that their experience was particularly good or bad. In the case of diagnosis or the broader experience of mental illness, patients who have a strong opinion about the experience are more likely to have composed and published a narrative about it than those who consider their experience typical or average. Still, the narratives available suggest that sizable contingents of “true believers” and “skeptics” exist among psychiatric patients, and that any theory of looping effects should account for these experiences.

V. Narrative finding: true believers stabilize

Woodrow Odom Lucas' narrative reflects the experience of the true believer. The “true believers” suggested that they fully identified with the DSM framework. The true believers' narratives were laden with language that implied that patients accepted its explanation for their disorder. These patients did not demonstrate any awareness of or reflection upon the normative aspects of psychiatric classification – that it may be value-laden or socially constructed, or may not be an objective reflection of “nature carved at its joints.” These patients' writing suggested that they assent to the DSM master narrative.

Lucas, a 36 year old male diagnosed with schizoaffective disorder, writes about his experience on the New York Times “Patient Voices” blog as follows (“Patient Voices: Schizophrenia”):

“The first time I began having symptoms of schizoaffective disorder was in 1999. I started to hear strange voices, not just comforting or guiding internal intuitions, but voices telling me that I was the spawn of Satan, or voices telling me that I was about to come under judgment...I really began to believe those voices. I experienced acute psychosis, which I thought at the time was a demon inside of my trying to take over my mind. Schizoaffective disorder is like a cross between bipolar and schizophrenia. The psychosis side and the delusion side is much less severe than schizophrenia but more severe than bipolar II. The mood swings in my opinion may be a little less severe than certain dimensions of bipolar so it's like worse than bipolar, better than schizophrenia,

and a mixture of the two.

In the beginning, it was horrific. I had a lot of ambition...all of this was shattered. My efficacy as a father was virtually gone. I felt like I had no love for my wife or anyone in the beginning months. I was extremely depressed, morose and disconnected. I think I've got a long way to go, but throughout it, because of the love of God and people, it's been a journey of hope."

The first characteristic of true believer narratives is that their authors claim their diagnosis. In the first lines, Lucas writes, "I began having symptoms of schizoaffective disorder." As opposed to saying, "I was diagnosed with" or "the doctors said I had" schizoaffective disorder, he claims it. Lucas also explains his behavior using the diagnosis – he describes the experience of a demon trying to take over his mind as "acute psychosis." His assent to the language of his diagnosis to identify his experiences is further evidence for his acceptance of it. Lucas also identifies with his diagnosis, so much so that he seems able to be familiar with what psychiatrists might consider a "classic presentation" of it, and place his individual experience in the spectrum he understands between the classifications of bipolar and schizophrenia. This understanding seems to suggest that Lucas generally "buys into" or trusts psychiatric nosology.

In her paper "Self-Insight in the Time of Mood Disorders: After the Diagnosis, Beyond the Treatment," Serife Tekin (another critic of Hacking's) points to peoples' "tendency to identify personal features with vague characterizations" that are prevalent in things like astrological readings, as cognitive bias. Lucas seems to demonstrate cognitive bias in his writing with his seemingly complete resonance with the explanation offered by his diagnosis. Tekin thinks that cognitive biases and their interaction with the dominance of the DSM master narrative may inhibit patients' ability to think about classification well by provoking patients to over-identify with symptoms at the risk of discounting other factors (Tekin, "Self-Insight....," 14). Tekin cites a patient's memoir of psychopathology where she notes that the testimony has traces of a DSM-led framework, and suggests that the patient accepted what she saw as a plausible explanation of her instability in DSM reasoning without considering or

“responding resourcefully” to vividly contingent interpersonal problems (Tekin, “Self-Insight...,” 26). Lucas' interpretation of his experience has traces of the DSM framework – in particular, his assertion that his symptoms can be characterized as “worse than bipolar, better than schizophrenia, and a mixture of the two” seems to attribute legitimacy and authority to the DSM explanation. Though his narrative does not provide enough evidence to draw a conclusion about this, Tekin gives us reason to wonder whether Lucas' assent to the DSM framework inhibits his ability to consider other factors in his life that may be affecting his mental health.

Lucas' narrative, like all true believers', suggests that true believers may attribute objectivity to their diagnosis without reflecting an awareness of its normative status. In their perhaps over-identification with generalized diagnostic language, true believers seem to either be ignorant of or apathetic toward the normative aspects of diagnosis and nosology more generally.

How do true believers' narratives support Tsou's response to Hacking? The evidence in Lucas' writing appeals to Tsou's submission that looping effects are typically weaker than Hacking claims, and undermines Hacking's idea that they make moving targets. Contra to Hacking's claim that the classifications and their objects are subject to a perpetual cycle of looping effects, the experience of diagnosis actually seems to have a very rapid stabilizing effect upon true believers who embrace and assent to the explanation of their diagnosis. Hacking does not provide an explanation for these stabilized objects of classification in his theory.

Hacking says that any object of human science classification is an interactive kind (Hacking, “Madness...,” 103). Tsou refines Hacking's claim to state that most objects of human science classification are actually interactive and indifferent kinds, with aspects of each: the looping effects which characterize interactive kinds, and the biological regularities of indifferent kinds. This adjustment to Hacking's theory, which claims that most objects of classification share underlying, law-like biological similarities with other objects of the same classification, provides early support for the

thesis that objects of psychiatric classification are less destabilized than Hacking predicts. Some shared biological aspect must limit or regulate the extent to which objects of classification can loop. Most objects of classification should be more stable than Hacking thinks.

True believers' narratives demonstrate that these objects of classification interact with their classifications in a certain way. Woodrow Odom Lucas and other true believers are most centrally characterized by their assent to the master narrative – their diagnosis informs and frames the experience of the mental disorder. The assent to master narrative causes extensive looping in one direction: the true believer “changes the way they experience themselves because they are so classified” to align more perfectly with the classification (Hacking, “Madness...,” 104).

True believers loop intensely to mirror their classification but don't demonstrate looping effects in the way Hacking expects them to: unceasingly (Hacking, “Making Up People...,” 3). True believers interact with their classification and are changed by looping effects only in order to correct any distance from the decree of their classification. Their buy-in to the DSM master narrative reflects an implicit conviction that the classification is stable; they may be ignorant of the normative status of nosology, or unconcerned by it. The true believer is stabilized by their belief in the stability of the classification and human science nosology in general. Tekin also observes this phenomenon in her notes on cognitive bias (Tekin, “Self-Insight...,” 14).

The true believers' narratives demonstrate a phenomenon that Hacking does not account for in his theory of looping effects, and which challenges his idea that objects and classifications are indefinitely destabilized in the human sciences. Jonathan Tsou's point that most objects of human science classification have both indifferent and interactive aspects suggests that objects' indifference will exert some initial stabilizing force. But beyond the presence of biological indifferences, it seems that the object of classification's orientation to the normativity of diagnosis demonstrated through whether they assent to the master narrative is telling for a theory of looping effects. True believers –

objects of classification that assent to the master narrative – will loop once with diagnosis, their narratives show, and are then stabilized.

The one direction looping effect of the true believers' interaction with diagnosis is an example of the weak looping effects which Tsou thinks Hacking fails to distinguish from the strong in his account. Tsou also claims that objects of classification are more stable than Hacking suggests. Hacking does not offer an interpretation of objects that have stabilized; Woodrow Odom Lucas and other true believers' narratives give us more reason to think, as Tsou does, that the experience of classification may make some objects of classification less subject to looping effects and less moving targets than Hacking thinks.

VI. Narrative finding: skeptics fall outside the looping effect

The patient narratives revealed another group of objects of classification whose diagnostic experience can be used to test for the integrity of looping effects theory. The narratives produced by these “skeptics” depict their rejection of the DSM explanation for their experience, and suggest a total renunciation of the master narrative framework. The experience of this group of psychiatric patients has largely gone unnoticed, ignored or disregarded in the scientific community's accounts of interaction with mental illness because these subjects tend to reject psychiatry as a whole, and disassociate themselves from it. Still, this experience should be considered in theories of interaction; to not include it is to deny the possibility of a complete account of the experience of diagnosis.

Most of the authors of the skeptic narratives claimed some association with the anti-psychiatry movement, which aims to take action for human rights violations in the mental health system (*MFI Portal*). A number identified as “psychiatric survivors” (*MFI Portal*). The narratives of these skeptics revealed their resistance to diagnosis as the exclusive explanation for their experience. Many assumed the “skeptical” position after a bad experience as a diagnosed person. A number expressed that their

resistance began when they found that their psychiatric caregivers were not concerned with features of their life external to the symptoms dictated by the diagnosis. Others recalled an experience which had provoked them to notice some aspect of normativity and become skeptical about the integrity of psychiatric nosology as a whole, citing it as a tool for social construction or control. As opposed to true believers, the central characteristic of the skeptics is that they display hyperawareness of the problematic normative aspects of psychiatric nosology. They find the classification so flawed that they reject the diagnosis altogether and remove themselves from DSM culture. In contrast to the true believers Serife Tekin cites in her discussion of cognitive bias and the master narrative, these skeptics develop a way to “respond resourcefully” to the challenges they face without interacting with DSM culture (Tekin, “Self-Insight...,” 26). This response makes skeptics outliers to DSM culture and the master narrative; they do not interact with it.

Skeptics' suspicion of the integrity of psychiatric classification may be connected to their personal experience of poor care or abuse as a patient in the mental health system. In some cases, this negative experience may have instigated their resistance to DSM culture, and awareness of the normativity of nosology may have followed. This path does not illegitimize the skepticism of patients' narratives for their “subjectivity;” all experiences of diagnosis are, as we have established, laden with subjectivity and value.

Their written narratives demonstrated the skeptics' hyperawareness of the normativity of psychiatric nosology. The skeptic phenomenon is epitomized in the narrative of Leah Harris, a former teenage mental health patient, whose writing was found on the “Beyond Meds – Alternatives to Psychiatry” blog (“Decolonizing our minds, freeing our spirits: Guest blogger Leah Harris”):

“I had just been released from yet another hospital for a half-hearted suicide attempt... I had alternately fought and reluctantly accepted a view of myself as “sick” and “disordered.” I hated the labels but identified with them at the same time...I had no tools, no frameworks, with which to redraw the maps in my mind... But slowly, I discovered that I could work with voices...I have gotten feedback from many people that when they

got a psychiatric label, it was a relief because it gave a name to what they had been experiencing. I don't discount the importance of a framework to make sense of our experiences, but who wants to be defined by a so-called illness?

I have found great validation...not from any psychiatric label but from friends in and out of the "mad movement." We see how various institutions and oppressions are connected...It matters not if we are "well" or "ill," "normal," or "disordered." I see our movement as... stealing back truths from industries that would have us only consume what they produce, whether it's ways of viewing ourselves or specific "treatments." They would have us believe that we are so "sick" that we don't know what's in our own best interest, and we resist that determination with all our might. We are teaching each other how to get free."

One of the primary characteristics of the skeptics is that they refer to diagnosis as a "psychiatric label," as Leah Harris does in her writing. This reference seems to imply the authors' awareness that nosology may be constructed for human use and may not reflect deeper truths about the world. Her use of quotations marks for the words "sick," "disordered," "well," and "ill" further implies her awareness of this construction, and the way that normative judgment is conveyed through these terms. Harris also seems to believe that her mental experience might be considered something other than an "illness" in another paradigm, when she calls it a "so-called illness."

Harris also seems to be aware of the factors that influence the way diagnosis is proliferated, as are most skeptics. She denounces the "institutions," "oppressions," "and industries" she sees as influencing her diagnosis and putting a monopoly on the way she should experience and deal with her mental states. Harris' awareness of the factors at play in her diagnosis seems to energize her quest to reject its definition of her. Her connection to the mad movement gives her resources to "respond resourcefully," as Tekin writes, to her diagnosis without legitimating the psychiatric label or institution (Tekin, "Self-Insight...", 26). Like all skeptics, Harris' narrative demonstrated how some classified objects' hyperawareness of the normative status of diagnosis, and psychiatry more generally, cause them to distance themselves from it, reject the claims it makes about their experience, and find alternative ways to address their mental health if and as they see fit.

In their responses to Hacking, both Tsou and Tekin seem to have missed another contingent of patients' diagnostic interactions – the skeptics! The skeptics are so aware of normativity of nosology that they deny it entirely. Their rejection of diagnosis and their refusal to assent to the medical master narrative mean that they do not interact with their classifications. They are made outliers to DSM culture and, moreover, move so far from their classification that they're no longer subject to looping effects. Skeptics' skepticism stabilizes them outside the looping effect. This skepticism and stabilization is depicted in Leah Harris' narrative. Hacking's theory does not account for outliers whose skepticism causes them to stand outside his phenomenon. Neither do Tsou or Tekin. Moreover, these skeptics' resistance to the looping effect gives us reason to think that patients' beliefs about normativity affect the way they interact with their diagnoses! More empirical research is needed to support this claim but, if founded, it has crucial implications for how information about how psychiatric and other human sciences classifications are proliferated by the DSM culture. Moreover, it would implore psychiatry to better account for skeptics' experience.

To Hacking, any object of human science classification is an interactive kind, characterized by how their awareness of their classification may "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" (Hacking, "Madness...", 104). Tsou holds that all objects of human science classification have interactive but also indifferent aspects – some shared biological regularities which ground and limit the interaction between the object and its classification (Tsou, "Hacking...", 331). Hacking thinks that what was known about interactive kinds may become false because the people of that group may change "in virtue of how they have been classified, what they believe about themselves, or because of how they have been treated as so classified" (Hacking, "Madness...", 104). This looping makes the objects perpetual moving targets, destabilized by their awareness of their classification.

Leah Harris and other skeptics' narratives revealed that the experience of this cohort of patients

is no doubt shaped by their status as interactive kinds and their awareness of being classified; in fact, their interaction is most characterized by hyperawareness of their classification. And this hyperawareness of their classification as a classification or "psychiatric label" – a claim about their own experience which is laden with normativity – causes the objects to move away from their classification as a rejection of it. This is the interaction particular to skeptical objects of classification: awareness of their classification causes them to react to it in such a way that they distance themselves from the master narrative and from DSM culture altogether.

The iteration of interaction characteristic to skeptical objects of classification actually has immense stabilizing force for its objects. Their awareness of the classification causes them to move so far outside the looping effect that they are no longer subject to it. They are stabilized because their conviction about the normative status of the entire classification scheme is what maintains their refusal to interact with it at all. By making claims that suggest they see through the master narrative, and denying the legitimacy of the nosology as a whole, they place themselves outside the looping effect. The skeptics' static belief about the normativity of the classification scheme actually stabilizes "what they believe about themselves" (Hacking, "Madness..." 104).

Skeptics are outliers to looping effects theory in the direction opposite true believers: as opposed to true believers' conviction about the stability of their classification and nosology in general which stabilizes them against further looping effects, skeptics' suspicion of their diagnosis and rejection of nosology stabilizes them outside DSM culture. Hacking's theory does not account for these objects of classification whose awareness of their classification causes them to reject its legitimacy and refuse to interact with it. The narratives of skeptics give us reason to think that the looping effects theory explicated by Hacking, Tsou and Tekin is not a comprehensive account of all of the ways objects of classification can interact with their diagnosis. Moreover, the narratives of the true believers and the skeptics suggest that patients' beliefs about the normativity of psychiatric classification may be relevant

to the way they interact with diagnosis.

VII. Beliefs about normativity influence interaction

Patient narratives reveal the strong stabilizing power of diagnosis for two types of patient responses to diagnosis which Hacking neglects to account for -- the "true believers" who fully identify with the DSM's "master narrative" framework; and the "skeptics," often identified with the anti-psychiatry movement, who reject the DSM explanation and mainstream psychiatric culture. The existence of these groups, as evidenced through their narratives, demonstrates another flaw of Hacking's looping effect theory -- that it does not consider these outliers.

I hold that their beliefs about the normative status of nosology are what distinguish true believers and skeptics from one another, and that it is the rigidity of their beliefs in either direction that explains how they become stable objects amidst Hacking's moving targets. More broadly, I submit that patients' beliefs about the normative status of scientific classification schemes, and psychiatric nosology specifically, influence the way patients interact with diagnosis. An awareness of the history of psychiatry and/or its normative function in society may be relevant to the formation of these beliefs.

The writing of the skeptics shows that belief that the nosology is fallibly normative is relevant in their rejection of its claims about their experience and in undermining the authority of psychiatry more generally. The skeptics' beliefs about normativity are typically characterized by their own negative or deceptive experiences within the mental health system, their hyperawareness of the extra-scientific agendas and pressures on the DSM, and perception of the master narrative as propagandist to some extent. Though references to its deeply normative, unscientific history are rarely overt in patient narratives, true believers seem to recognize the historically normative function of psychiatry, and reject it because of this legacy. It is easy to see how familiarity with the history of the concept of mental illness and nosology described earlier in this paper might develop patient skepticism. It is also easy to

imagine that acquaintance with other skeptics or anti-psychiatrists before or in the course of diagnosis might influence skepticism towards one's diagnosis. The mad movement Leah Harris describes association with seems to provide support and solidarity for resistance to the what she sees as the master narrative (“Decolonizing our minds, freeing our spirits: Guest blogger Leah Harris”). The skeptical community seems key to skeptics' rejection of diagnosis and nosology and seeking of alternative responses. The skeptics' written narratives made it clear that their interaction with diagnosis were framed by these beliefs and experiences.

True believers' beliefs about the normative status of nosology are not overtly available in their writing. However, from the absence of normativity claims or references in the narratives, we can make inferences about these beliefs. True believers either don't recognize the normative status of nosology, or don't see it as a problem. If true believers do not think that nosology is normative, we can infer that perceptions about the non-normative status of nosology may influence their interactions with their diagnosis. Or, if they acknowledge normativity but don't it as a problem, we can infer that their disregard for the normative status of nosology may influence the way they respond to their diagnosis.

Further empirical research is needed to support the claim that patients' awareness of the normativity of nosology affects the way they interact with their classification. Quantitative research is needed to develop a better understanding of what proportion of psychiatric patients experience diagnosis as skeptics or true believers. And research more directly examining patients' beliefs about and awareness of normativity and its problematic aspects is needed to determined whether the relationship between beliefs about normativity and interaction with diagnosis is truly causal. Specifically, research should attempt to get more information about the state of true believers' beliefs and awareness of normativity, and better identify those variables most influential in skepticism. All of this research would make valuable contributions to scholarship on beliefs, science and psychiatry, and could be useful to psychiatrists seeking to better and more accurately present information on nosology and

diagnosis to lay people.

VII. Conclusion

An account of the history, normative status and social function of psychiatric diagnosis is critical to understanding how patients interact with it. This paper analyzed first-person patient narratives of psychiatric diagnosis to determine whether the narratives reflect Ian Hacking's looping effects account of patient interaction. The narratives supported Jonathan Tsou's claim that psychiatric patients are more stable, less "moving targets" than Hacking thinks. While Hacking and Tsou highlight the ways patients interact with diagnosis and cite the biologically indifferent aspects which ground interaction, they neglect to account for a crucial factor in patients' interaction with diagnosis: their beliefs about the normative and scientific status of diagnosis and the psychiatric institution more generally. The writing of "skeptics" and "true believers" shows that patients' beliefs about the normative status of psychiatric nosology affect their response to and interaction with diagnosis. We can imagine that these beliefs are formed in light of patients' perceptions of the history and social role of diagnosis.

The claim that patients' beliefs about normativity affect their interaction with diagnosis provokes many interesting future investigations. How do we develop a nosology increasingly void of problematic normative aspects? How do we mediate between the competing interests of the psychiatric institutions and the goals for psychiatric nosology? How should scientists communicate the normativity inherent to science accurately and accessibly? What factors influence the extreme positions of the true believer and the skeptic? Do features of their diagnosis predispose them to respond with assent or paranoia? How does patients' access to a community of patients influence the way they interact with diagnosis? How do we construct an theory of interaction that includes skeptics, who become outliers to nosology and the psychiatric institution? In addition to philosophical work, empirical research is

needed to clarify the relationship between beliefs about normativity and reaction to diagnosis. This research is crucial for developing a more accurate account of patients' interactions with diagnosis, and for offering better psychiatric care for those who wish to seek it.

Annotated bibliography

Cooper, Rachel. *Classifying Madness: A Philosophical Examination of the Diagnostic and Statistical Manual of Mental Disorders*. Dordrecht, The Netherlands: Springer, 2005. Print.

Cooper's book takes on all of the questions I would were my thesis a dissertation! She is a contemporary of Tsou (in fact, he was an early reviewer of this text). Most helpful for my research, Cooper offers a great response to the question of whether a classification scheme that truly represents "nature carved at its joints" is possible.

Cooper, Rachel. "Is Psychiatric Research Scientific?" *Psychiatry as cognitive neuroscience: philosophical perspectives*. Eds. Matthew Broome and Lisa Bortolotti. Oxford: Oxford University Press, 2009. 13-27. Print.

This article helped to answer some of the earlier questions I was interested in, and ended up not including in my final draft, related to Popper's theory of falsifiability and the status of psychiatry as a "soft science."

"Decolonizing our minds, freeing our spirits: Guest blogger Leah Harris." *Beyond Meds. Beyond Meds -- Alternatives to Psychiatry Blog*, 15 March 2009. Web. 6 April 2013.

This is the article I used as my true believer narrative. Beyond Meds' name suggests its skepticism; most of the writing on the site is first-person narrative of diagnosis, and was very helpful for developing my conception of skeptics.

Foucault, Michel. *Madness and Civilization: A History of Insanity in the Age of Reason*. London: Vintage, 1988. Print.

Foucault's famous social constructivist account of the history of the concept of madness is fascinating, and informed my claim that patients' interactions with diagnosis might be shaped by their beliefs about and awareness of psychiatry's normative status and history.

Hacking, Ian. "Making Up People." *The London Review of Books* 28.16 (2006): 23-26. Online.

This is where Hacking's looping effects theory is described for a non-philosophical audience. It was helpful to merge his presentation of concepts in this paper with the more explicitly philosophical presentation in "Madness: Biological or Constructed?" to provide a more accessible account of looping effects in my paper.

Hacking, Ian. "Madness: Biological or Constructed?" *The Social Construction of What?* Cambridge, MA: Harvard University Press, 1999. 101-125. Print.

In this paper, Hacking first outlines the concepts of interactive and indifferent kinds, and his theory of looping effects. This paper presents these ideas in a more complicated way than "Making Up People," but is helpful for getting a sense of Hacking's early thinking on looping effects, seven years before "Making Up People" was published.

Half of Us. *mtvU Channel and The Jed Foundation*, 2006-2013. Online. 10 April 2013.

Half of Us is an MTV-sponsored project which aims to raise awareness of the prevalence of mental illness among young people. I found many helpful video accounts, mostly by patients who would be considered to be true believers, on this site.

Hansson, Sven Ove. "Science and Pseudo-Science." *The Stanford Encyclopedia of Philosophy* (Winter 2012 Edition). Edited by Edward N. Zalta. Online.

The Stanford Encyclopedia of Philosophy is a great standard reference for many issues in philosophy. I used this article when I was thinking about developing the thesis around Popper's account of falsifiability and pseudoscience; these ideas did not make it into my final paper.

"I have schizophrenia." *Experience Project*. Experience Project, 2007-2013. Online. 10 April 2013.

The Experience Project calls itself a place for "true stories shared by real people," and has forums for people with all kinds of experiences. The "I have schizophrenia" page is helpful for getting a good idea of types of people who write on the internet about mental illness; both true believer and skeptical viewpoints are well-represented.

Kendler, Kenneth and Peter Zachar. "Psychiatric Disorders: A Conceptual Taxonomy." *American Journal of Psychiatry* 164.4 (2007): 557-565. Online.

The six conceptual dimensions of psychiatric classification outlined in this article captivated me early on in my research. In my paper, in defining normativity, I reference the objectivism/evaluativism and essentialism/nominalism dimensions. This paper affirmed my burgeoning idea, early on in the semester, that peoples' beliefs about the scientific status of nosology might affect how they respond to them.

Kawa, Shadia and James Giordano. "A Brief Historicity of the DSM: Issues and Implications for the future of psychiatric canon and practice." *Philosopher, Ethics and Humanities in Medicine* 7.2 (2012):1-9. Online.

This article discusses the evolution of the DSM since its inception, and was helpful in bridging Foucault's distant account of the history of mental illness with the more imminent implications.

***MFI Portal*. MindFreedom International. Online. 8 March 2013.**

MindFreedom considers itself a "voice of the movement against human rights violations in the psychiatric system." It features extensive accounts of people with experiences with psychiatric diagnosis, with varying levels of skepticism. The narratives on this site were helpful for developing my conception of skeptics.

***NAMI: National Alliance on Mental Illness*. National Alliance on Mental Illness, 1996-2013. Online. 10 April 2013.**

NAMI is the US' largest nonprofit, grassroots mental health education, advocacy and support organization. The site doesn't seem to offer access to many first-person patient narratives without membership to their online support network. Some of its programming is sponsored by pharmaceutical companies, interestingly; I imagine skepticism is not suggested in the narratives it makes available.

"Patient Voices: Schizophrenia." *The New York Times*. The New York Times Company, 16 September 2010. Web. 6 April 2013.

The site provides accounts of peoples' experiences of difference diagnoses. It is the source of the "true believer" article by Woodrow Odom Lucas.

Phillips, James, et al. "The six most essential questions in psychiatric diagnosis: A pluralogue part one: Conceptual and definitional issues in psychiatric diagnosis." *Philosophy, Ethics and Humanities in Medicine* 7.3 (2012). Online.

This article did not make it into my final draft, but it helped me get a comprehensive sense of the conceptual issues in psychiatry early on.

Popper, Karl. "Science." *Conjectures and Refutations*. London: Routledge, 1963. 33-39. Print.

I did not end up incorporating Popper into my writing, but his seminal idea that any good scientific theory should be falsifiable was formative in my thinking about the normative status of classification schemes.

Radden, Jennifer. "Recognition rights, mental health consumers and reconstructive cultural semantics." *Philosophy, Ethics, and Humanities in Medicine* 7.6 (2012). Online.

Radden's powerful article directly takes on issues of justice and policy in the mental health system. In it she introduces the concept of the "master narrative" of biomedical psychiatry, a narrative so powerful that it construes the reality of alternative, first person accounts of psychiatric diagnosis. This concept helped me sharpen the distinction I made between the true believers and the skeptics.

***Rethink Mental Illness Help*. The Schizophrenia Foundation, 2002-2013. Online. 11 April 2013.**

A support group site for patients and caregivers sponsored by The Schizophrenia Foundation, it was one source for mostly true believing patient narratives.

Silvers, Anita. "Formal Justice." *Disability, difference, discrimination: Perspectives on justice in bioethics and public policy*. Ed. Anita Silvers, David Wasserman, Mary B. Mahowald. Oxford: Rowan and Littlefield, 1998. 1-78. Print.

Silvers' article "Formal Justice" provides a detailed account of Norman Daniels' "normal species functioning" that I used to add clarity to my definition of normativity.

Tekin, Serife. "A Query into Mental Illness Memoirs: Does writing help psychiatric patients?" *Neuroethics and Law Blog*. Adam Kobler. 2009. Online.

I stumbled on this article early in my research process; it provoked me to think about using patient writing to test Hacking's theory.

Tekin, Serife. Forthcoming. "Self-Insight in the Time of Mood Disorders: After the Diagnosis, Before the Treatment." *Philosophy, Psychiatry and Psychology*. Online.

In my thesis, I cited Tekin's notion idea that "DSM culture" and "cognitive bias" may inhibit patients' self-insight in response to diagnosis. These concepts were helpful for furthering my argument about the presence and implications of reckoning with the normativity of classification in the context of the master narrative (Jennifer Radden's idea).

Tekin, Serife. "The Missing Self in Hacking's Looping Effects." *Mental Kinds and Natural Kinds*. Cambridge, MA: MIT Press, forthcoming. 1-38. Online.

This response to Hacking claims that his looping effects theory is missing an account of the self, and uses a patient memoir as evidence. Tekin accuses Hacking of neglecting the subjectivity and complexity of selfhood in the patients' encounter with diagnosis. The analysis of this memoir provoked me to think that other autobiographical mental illness narratives may reflect cognitive bias or respond to the master narrative in some way.

Tsou, Jonathan. "The Importance of History for the Philosophy of Psychiatry: The Case of the DSM and Psychiatric Classification." *Journal of the Philosophy of History* 5 (2011): 446-470. Online.

This paper is, in part, a response to Rachel Cooper's position in *Classifying Madness* that, in its current climate, a DSM that depicts "nature carved at its joints" is impossible. Moreover, it asserts that examining the DSM in the context of its history can be really helpful for answering questions about its potential. I appreciate Tsou, and this paper, for taking the approach of situating issues in their historical context that I think is so critical to an informed response to issues in the human sciences.

Tsou, Jonathan. "Hacking on the Looping Effects of Psychiatric Classification: What is an Interactive and Indifferent Kind?" *International Studies in the Philosophy of Science* 21.3 (2007): 329-344. Online.

This paper contains Tsou's response to Hacking's looping effect theory. I used this paper to support the claims I make about how the narratives show that patients are more stable objects of classification than Hacking thinks.