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ORIGINAL ARTICLE

Formation and meaning of mental symptoms: history and epistemology

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Historical evidence shows that mental symptoms were constructed in a particular historical and cultural context (19th Century alienism). According to the Cambridge model of symptom-formation, mental symptoms are mental acts whereby sufferers configure, by means of cultural templates, information invading their awareness. This information, which can be of biological or semantic origin, is pre-conceptual and pre-linguistic and to be understood and communicated requires formatting and linguistic collocation. Mental symptoms are hybrid objects, that is, blends of inchoate biological or symbolic signals and cultural configurators. 'Culture' plays a very deep role in symptom-formation because templates can attenuate or abolish the specificity of the biological signals involved. This means that signals from different brain sites can be configured as the same symptom and signals from the same site as different symptoms. Although always present, the neurobiological substratum is not fundamental in the understanding and management of mental symptoms. These can only be comprehended in relation to the manner of their construction and the cognitive and emotional biographies of each patient. Direct interference with the brain sites involved may dull mental symptoms but is unlikely to offer long-term cure. If the configuratory style and needs of the patient are not understood and dealt with, he is likely to keep re-constituting or replicating his symptoms in relation to other biological signals. In summary, mental symptoms are not passive happenings but genuine mental acts. Hence, the manner and motivation of their construction may be more important than the signal of brain distress that might have provoked them in the first place.

Keywords: philosophy of psychiatry, epistemology of psychiatry, psychopathology, history of psychiatry

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LECTURE

Thank you, I do appreciate your words and your invitation. I have been asked by Massimiliano to tell you a bit about my work. Basically, when I was active my department in Cambridge had two branches. One was dedicated to neuropsychiatry research. I was the head of the department of neuropsychiatry, having started my life as a neurologist. The other side of my work was conceptual. It was possible to do that in Cambridge years ago. On the conceptual side we did both historical and philosophical works.

What I'm going to do today is to present a summary of our conceptual work. So, the lecture is going to be called "Mental symptoms: formation and meaning", and what I want to do is tell you about some of questions researched upon by the Cambridge group.

We asked questions in macro-epistemology; this work has continued after my retirement. The central macro-epistemological question is what is the *nature*, *origins*, *limits*, *stability*, and *legitimacy* of the language of psychopathology.

We are also interested in the *lasting power* of psychopathology, that is how quickly the language of psychopathology goes out of *calibration* (in other words, it no longer captures the psychopathological phenomena).

Then, we have been interested in the epistemology of psychiatry itself. We want to know whether the epistemology of psychiatry ought to be general, as part of the epistemology in medicine, and indeed of biology, or whether in fact psychiatry is such a *sui generis* activity that requires a regional epistemology to manage it. We believe that psychiatry, on account of its historical origin and of the particular structure of it, requires a regional epistemology. Then, we are interested in looking at the contexts, the venues and the practices of psychiatry, that is the need to know about the warrants of psychiatry as a practice: obviously we have scientific warrants, but we also require social and ethical warrants.

And finally, during the last two or three years we have been very interested in the concept of reification as applied to biological psychiatry.

In relation to the micro-epistemology, we have been asking the following questions.
First, questions regarding what we call the "primary objects" of psychiatry, i.e. the mental symptoms: what are the *nature*, *formation*, *meaning*, and *structure* of these primary objects. And, secondly, we have been interested in what we call the "derivative objects", which are the mental disorders. This means that the primary unity of analysis in psychiatry is the mental symptom; historically that is the case, it might change in the future but nowadays it is the mental symptom. Mental disorders are symptom clusters and they are higher level organizations and they are not particularly interesting in themselves.
And finally, we are interested as scientists and as medics in what I called the "generators" and the "configurators", that is the constituents of the so called *ætiology* in psychiatry. Here there are concepts like *reductionism, localisationism, psychogenesis*, which is particularly interesting, *semantic spaces,* the problem of *reasons vs. causes*, in relation to psychiatry.

Of all those questions, today I will only talk about this: *formation*. What do we know about our mental symptoms' formation? In a very old manifesto, which started the Cambridge School (Berrios, 1984), we settled a list of ten-twelve conditions which we needed to investigate and I'm pleased to say to have done most of them so far. This is the paper were we posed the idea that descriptive psychopathology is a cognitive system constituted by terms, assumptions and rules for its application; it is a language of capture, of modulation, and of control. In 1993 we started this work (Berrios and Chen, 1993), which has since being replicated everywhere, where we used neural networks to demonstrate a very specific fact: that the DSM-III two stage model, according to which symptom and disease recognition are independent cognitive events, did not work. That you cannot recognize symptoms and then, when symptoms are fully recognized, you have the disease by putting them together. The disease hypothesis absolutely controls the way mental symptoms are captured and recognized.

Recently we decided to write a summary of our work (Marková and Berrios, 2012). For the epistemology of psychiatry an important question is what *(in biological, evolutionary* and *cultural terms)* has come first: were the mental disorders or the mental symptoms? It is a question apparently simple, but it is probably a trick question. This because it is the context that will determine what will be the answer. However, it is a very important question to ask in order to trigger research in this field.

The concept of mental symptom has been with us since the 1810s, and I will briefly mention very important landmarks which participated in the construction of this concept. Certainly Landré-Beauvais, who wrote a very important book in 1813. He developed the idea of the symptom *in general* as a sign. At the time, the concept of sign was already used in linguistic theory, which was very important, and that at the beginning of the 19th Century influenced medicine. Bayle, Georget, and Jules Falret applied Landré-Beauvais' ideas to alienism, and they said that these signs were brain related. This is the first claim that we have that mental signs are related to the brain. In 1845, in the first edition of his book, Griesinger talks specifically about *elementary anomalies*, which is the name he used for mental symptoms. He claims that these elementary anomalies should be used as the units of analysis of psychiatry. Then, many more followed. I used to give five lectures on symptom formation in my university. Each of these contributions deserves a talk. Moreau de Tours with the concept of "primordial facts", Baillarger who distinguished for the first time between form and content, and J. P. Falret (the son) who talked about the context of symptoms. This is particularly important; a great friend of mine, Georges Lanteri-Laura, who died some years ago, dedicated a lot of his work to this particular concept. He believed that the introduction of context in the formation of mental symptoms was a great contribution of Falret, which was lost later on (for example, you have not mentioned it in Jaspers). The list continues, some other contributors being very important. For example, Jackson talked about mental symptoms as "release" phenomena, and Ribot

and Janet clearly followed that view, as indeed did Freud. Freud was very influenced by Jackson's model. The idea that mental symptoms are in fact atavic behaviours that are preformed, because they appear in some way in the evolution, and that they had been basically inhibited but that in the course of mental illness were disinhibited, was very much the contribution of Meynert. The contribution of Freud is of course very important; he developed a new definition of symptoms as symbols and routines for conflict resolution. This introduced a new interpretive view that tragically was subsequently lost. The basic other contribution is Max Hamilton's, my teacher, the great mathematician who developed the Hamilton Depression Scale; he developed a new idea of mental symptoms as measurable items that could be treated by a statistician. And finally I have to introduce our own views, in Cambridge, that define mental symptoms as biological signals which are culturally configured.

Basically, what we now call "mental disorders" were constructed during the 19th Century. We can start with Pinel's nosology at the beginning of the Century, and we are going to the great nosologists of the late 19th Century (people like Pick, Falret, Séglas, Kraepelin, Chaslin). The nosology we have now has its roots in 19th Century alienism. At the beginning the nosologists had five categories (phrensy, mania, melancholia, dementia and idiocy), but these categories were monolithical, they were metaphysical. Once you had one of them, you always had to have it. The problem was how to explain improvement. The explanation that they developed was the concept of lucid interval. If you improved, then you had had a lucid interval, but you were still mad. Madness was still in your brain, in your body, but you had a lucid interval. Now, the early-19th Century concepts of mania, melancholia, and even dementia, have nothing to do with the concepts that we have now. Something happened during these one-hundred years. There was a complete change for these categories. They changed in meaning, they changed in content.

A psychological theory, which was generated by John Locke and brought into France by Condillac, called "Association Psychology", became very important following Newtonian philosophy, and the alienists had to start to changing their way to see the unity of analysis in their discipline. It was the analytical Newtonian philosophy that reached medicine. Basically, in this period all the former categories were fragmented into basic unities of analysis. This is a very confuse period in 19th Century European psychiatry. Some of the symptoms survived, like hallucinations, delusions, obsessions; other symptoms disappeared, and for the historian of psychiatry those symptoms that did not survive are also very important. In the 1850-1860s, Association Psychology goes out of fashion and a new psychology arrives in Europe, and that is called "Faculty Psychology". This psychology has two origins: one is the Scottish philosophy of common sense, who had a great impact in Germany and France, and the second origin is phrenology. Phrenology is one of the great sciences of the 19th Century. As the question arrives, it is how to classify the functions of the mind. Through the interest of the New Kantian philosophers, Kant is rediscovered. Kant provided the three basic concepts: the so called intellectual faculty, the emotional faculty and the volitional faculty. It is extraordinary how alienists reshaped their categories: some forms of madness became primarily disorders of the intellectual faculty, other forms of madness are primarily disorders of emotions, and other forms of madness are primarily disorders of volition. And this provided the glue, the clustering force in which terms a new set of mental disorders appeared. And this is the way in which schizophrenia (dementia praecox), paranoia and chronic hallucinatory psychoses appeared as disorders of the intellectual faculty, and mania was for the first time put together with melancholia as primarily disorders of emotions (this new concept of mania had nothing to do with the older one). And finally, between the end of the 19th Century and the early 20th Century, the personality disorders appear as primarily disorders of volition. So, it seems very clear that the way to classify disorders nowadays is firstly from the psychopathological perspective, in terms of three functions, and secondly neurobiologically: e.g., in the case of primary disorders of the intellectual faculty we look for those areas in the brain that are supposed to be responsible for the primary

disorders. And of course this also applies to the emotional disorders, where we look for the corresponding areas in the brain. As shown by many great historians of psychology, basically we classify, we separate, we cluster mental functions, and then they are transferred into psychiatry, in a way that seems to me totally illogical. And it is claimed that we have the neurobiological instruments to test it. In every historical period psychiatrists claimed that they had the instruments to do it, for instance the electroencephalogram in the 1930-1940s; they were sure that they had the instrument to determine the mental functions. Later the same happened with neurochemistry, and nowadays people have the same talk about neuroimaging. This is why the questions "what are the objects of psychiatry?", and "how stable are they?" remain very important.

So, mental symptoms, syndromes and disorders are currently considered as the objects of psychiatry and they therefore act as units of analysis and classification. In the predominant view, which is the absolute view of the biological psychiatry: a) the psychiatric objects are real things, like flowers or animals, they exist in concrete situations (i.e., they are "natural kinds"), and b) their classification must be modelled upon biological taxonomy, and here is seen the mathematical work in medical taxonomy. For example, there was a claim in psychiatry to develop the idea that there is a kind of taxa, a kind of stable ontology which is classified.

Now, the view of the Cambridge Group is that the structure of psychiatric objects is not eternal but is determined by the manner, the period and the cultural purpose of their construction. Each cultural period has a purpose, and this purpose is written in the way mental symptoms are developed. So, we should ask: psychiatric objects are "object for what?" (for seclusion, treatment, protection, etc.). This will be reflected on the way they are constructed. If this is the case, if the structure of mental symptoms is culturally determined, then they are not concrete objects, they are not ideal objects, but they are "hybrid objects", and this creates all kinds of conceptual difficulties.

This brings us to this real issue: What is the role of "culture" in symptom-formation? Everybody says: "Of course this is important". Everybody pays lip service to culture. However, when you press them, and nowadays within the phenotype idea you ask what exactly is the role of culture in the formation of phenotype, people begin to think about it and say: "Well, it is on the content of the symptoms. If you were Chinese or Peruvian you would have other objects for your hallucinations". But basically that's all they admit. In their view the form is absolutely universal. My point is that that is not good enough; the issue is "How deeply culture formats the mental symptoms?" Concerning the structure of mental symptoms I would recommend a paper with Ivana Marková on the epistemology of mental symptoms (Marková and Berrios, 2009), where we separated and analysed the structure of mental symptoms and considered many consequences that are important for psychiatry.

It is time now to define hybrid objects. What is a hybrid object? There are a number of reasons for this, but the basic one, the basic reason why alienism, now called psychiatry, tends to generate hybrid objects ... The reason is this: when alienism develops as a discipline, in the 19th Century, there is a major debate going on between the natural sciences (*Naturwissenschaften*) and the social sciences (*Geisteswissenschaften*). Hybrid in general means here: "Anything derived from heterogeneous sources, or composed of different or incongruous elements…" (Oxford English Dictionary, 2nd Edition).

Hybrid objects have some specific, interesting and complex features, which are the following:
a) a physical kernel; there is always a physical kernel but in the case of mental symptoms it is regularly subjected to cultural configuration;
b) therefore, they have a very dense semantic wrapper or envelope; they are wrapped up, they have an envelope of semantics which very largely controls, informs and sometimes abolishes the powers of the physical kernel;
c) they have their own causal powers. Concrete objects are part of traditional Newtonian physics, and ideal objects are part of semantics, e.g., virtues. For example how virtues are conveyed in someone's behaviour; you don't need to have a neurobiological account of that. Hybrid objects have both, and this is what makes them so diffi-

cult to handle. They have both causal parts, they are part of neurobiology but they also act as ideal objects. In other words there are causes but there are reasons as well;

d) For all these reasons, hybrid objects have special taxonomic and representational requirements.

So, if we want to represent the hybrid objects, it would be something like this (see Figure 1). There would be a biological signal, or kernel; there would be the first wrapper, the cultural configurators, which are quite strong; and there would also be a very important second envelope, which is often forgotten and which is the outcome resulting from dialogical negotiation. The clinician and the patient have their particular dynamics of interaction. The clinician is not the secretary of the patient, as the DSM-IV requires us to act: i.e., the patient tells the symptom and the clinician writes it down. There is a strongly complex dynamic which creates a dialogical negotiation; there is a conceptual and emotional negotiation which contribute enormously to the formation of symptoms. So, a number of issues follow:

a) Which informational source predominates here? Should it be, as the biological psychiatrists believe, *always* the biological signal that determines the phenotype (i.e., the symptoms), or the *cultural* configurators can actually govern the expression of the symptom, or indeed the negotiation that takes place?

b) How permeable the two envelopes are to the informational content of the biological signal?

c) How stable in time is this structure? Does it change according to the duration of the disorder?

d) Does the "informational aperture" vary according to each mental symptom? The Cambridge Group believe that the informational aperture will vary from symptom to symptom. It is likely that some mental symptoms are biologically driven and that there are others where cultural configurations are particularly strong. At this stage we are exploring these differences because we had got no positive criteria to separate them, but this is important because it has even therapeutic applications.

In the Cambridge model there are four pathways (a, b, c, & d) of mental symptoms formation, and we will talk here of pathway (a) and pathway (b). In pathway (b) the brain signal totally by-pass awareness and causes changes of behaviour of which the patient may not be aware. Therefore, this pathway generates mental symptoms which can be considered as a more or less direct expression of brain signals. On the contrary, in the case of pathway (a) there is always a brain signal and there is always symptom construction (Figure 2). The brain has to be involved but something more complicated happens. What happens is this: the signal will penetrate awareness and the individual suddenly feels something different, something which he had not felt before. This experienced change,

Figure 1

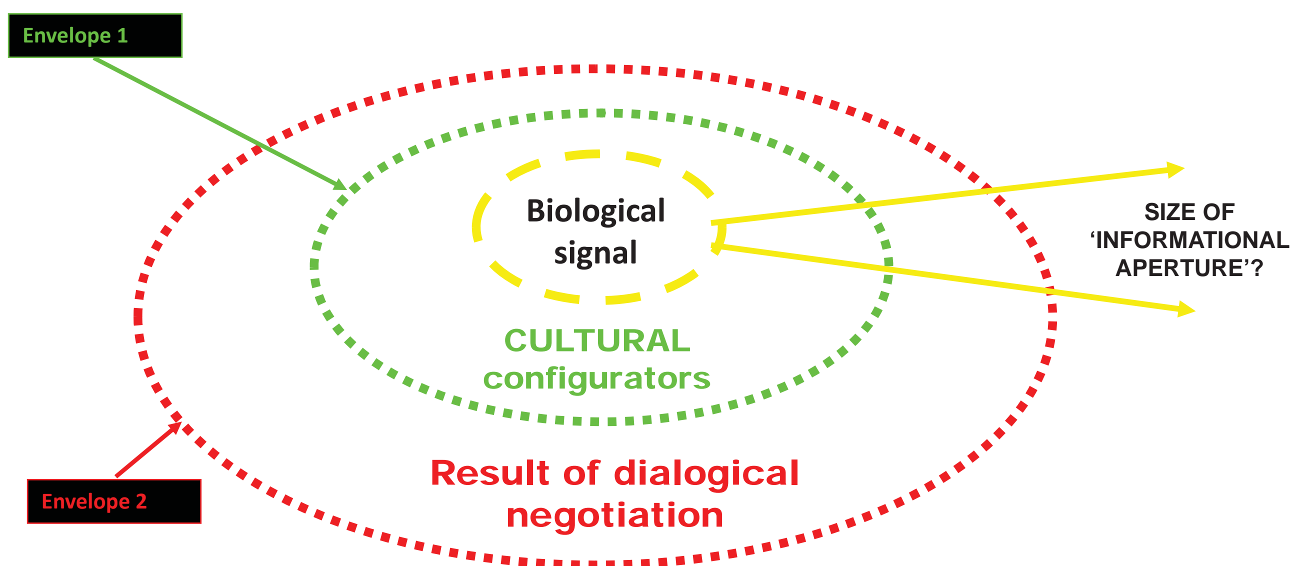
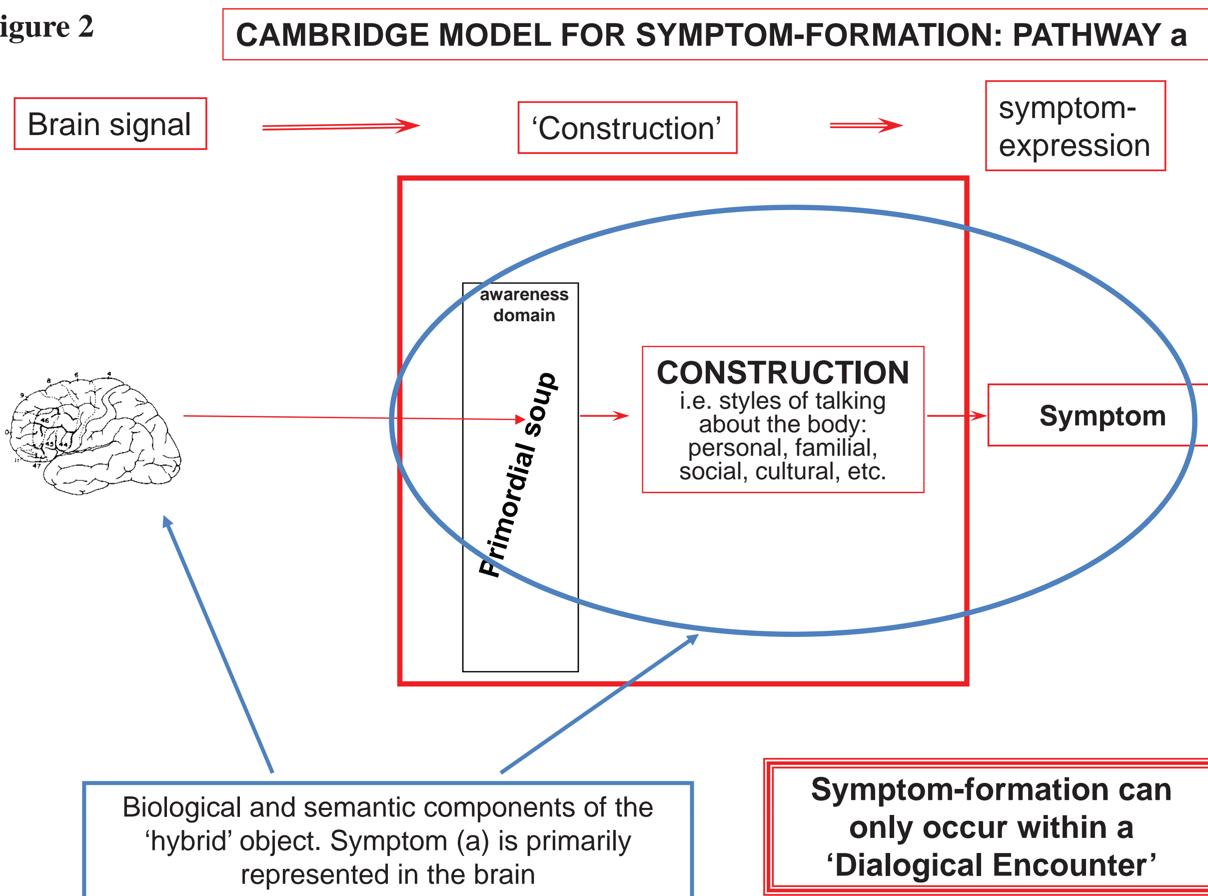


Figure 2



which the subject may have for the first time, is pre-linguistic and pre-conceptual (the individual doesn't even know whether it is an emotion, an image or a thought). We have called it the "primordial soup"; it is our way to refer to sensations which you have not had before and that, in order to communicate them, you need to construct, you need to relate to concepts you may or may not have. If the individual wants to communicate this pre-conceptual and pre-linguistic experience, he needs to construct it, as we need to construct everything else. There are formats, there are configurators, there are cultural configurators, there are social configurators, there are familial configurators and there are personal configurators. Once the sensation has been fully configured can this distress coming out and then it is expressed.

This model is heuristical because it allows a number of options and relations. For example, one interesting option is that signals from the same region of the brain may be conceptualized differently and may give rise to two different symptoms. So, there are two mental symptoms but they have the same neurobiological origin. The opposite is also the case: you may have signals from various parts of the brain which happen to be configured in the same way and you are reporting them as the same, although of different origin. For example, hallucinations and delusions can be closely connected. We believe that at least in some cases you may have a situation where the primordial soup is not clear, when whether it is an idea or an image it is not clear. The clinician and the negotiation with the patient have an important role. When the clinician has the suspect that the patient has schizophrenia or some other disorder, the clinician may guide the patient implicitly by asking "Are you seeing things or it is just a thought that you have?". This is a very interesting negotiation because if the patient eventually decides that it is a thought it becomes a delusion, whereas if the patient says "No, it is an image, I'm seeing this", it would probably be rated down as an hallucination.

So the issue is important, for example when you are looking at the possibilities within a neuroimaging system. The Cambridge model is gen-

erating interesting predictions in many fields, and I believe also in neuroimaging. For the first time we do have a model of how mental symptoms are formatted. You see, the way biological psychiatry interprets diseases is that the bit of the genome generates the endophenotypes and then the phenotype; and culture somewhere helps but the way it does so is unclear and the mental symptoms are not really involved. The important is something else, coming out from the genes.

In psychiatry and psychology we need more than that. I think that the mental symptoms are crucial. Being hybrid objects, they show this complex constitution (Figure 1). The construction provides the envelops, the negotiation provides the envelops, and brain provides the biological signal. So, when redefined as hybrid objects, the brain localization (e.g. neuroimaging) of mental symptoms poses an interesting epistemological problem, because the brain signal is only one component of the final symptom, whose formation is culturally, socially, and personally shaped by both the patient and the interviewer. Being brain signals configured by cultural codes, in the Cambridge model one signal may give rise to <u>different</u> mental symptoms and different signals can be configured as the <u>same</u> mental symptom, therefore posing interesting challenges to neuroimaging research.

In fact, mental symptoms can be primarily and secondarily "represented" in the brain:

a) Primary representation or "localization" refers to modifications in a brain locus consistently correlated to a mental function or state;

b) Secondary representation or "inscription" refers to temporary modifications in a brain locus resulting from a transient correlation (à la Kelso) with a symbolic object.

Accordingly, the primary-secondary distinction does not imply any difference in the clinical importance of the symptoms themselves but indicates different pathways of symptom formation. One noteworthy clinical implication is that primary representations may be more susceptible to biological therapy, whereas secondary representations shall be more appropriately managed in psychological/semantic terms.

In conclusion:

a) The epistemology of psychiatry explores the hidden conceptual structures that lend coherence and meaning to empirical research;

b) An important question in this regard is whether, in biological and cultural terms, mental disorders or mental symptoms should be considered as having come first;

c) Research into the cultural perspective suggests that mental symptoms seem to have both ontological and epistemological priority;

d) This finding clashes with the conventional biological view that diseases have ontological priority and mental symptoms are but secondary and mediated clinical expressions;

e) The Cambridge model of symptom-formation offers a solution to this aporia and shows how brain signals and personal, familial, social and cultural configurators interact within a dialogical context to give rise to the mental symptoms in their final form.

DISCUSSION

M. Aragona. Thank you very much German for this beautiful lecture which was really reach and with so many interesting points soliciting a reflection. I have many questions but I prefer to give the audience the opportunity to directly ask you their own questions. I thank Giorgio Kotzalidis for his very kind and fundamental help in the translation.

T. Fenelli. Could you please describe again the concept of "primordial soup" which was not very clear to me?

G.E. Berrios. The idea that sensations come to awareness in a raw form and that then they are rapidly processed is one which comes from William James. You know, William James had already talked about sensations.

We don't realize this consciously because we have templates already available, acquired during our development, and so when we are checking around, the templates are rapidly found; basically information comes in a great speed. We have certain templates which allow us to rapidly checking up, identify and classify it.

The problem with mental symptoms is that often enough there are sensations that the patient or the individual has never had before, particularly in the first episodes of psychosis. And that is what ordinarily happens, that when the patient,

or the person, looks for templates to account for this, he finds nothing, basically. The perplexity, which Conrad understood and described so beautifully years ago, which the patient in the first episode of psychosis has, is so extraordinary.

It is only in that situation that you have primordial soups, which are pre-conceptual and prelinguistic, simply because no formats are available to the individual to conform and configure them. Normally we don't have that problem, and indeed the chronic patients may not have that problem as well, because they have developed templates which are available to configure it.

T. Fenelli. So, in a way the chronic patient is more close to the healthy person.

G.E. Berrios. No, it is not exactly this that follows, but he has a mechanism to cope with.

E. Guarracino. Just a comment. In this model the concept of dialogical negotiation is very important. I would like to understand Prof. Berrios' opinion about the perspective of descriptive psychopathology in this case.

G.E. Berrios. The only way in which descriptive psychopathology is going to survive will be by taking both, by taking into account the fact that this negotiation takes place.

I believe that the problem with descriptive psychopathology nowadays is still that little of it does exist. It is that many descriptive psychopathologists believe in a kind of 19th Century positivistic involvement; they believe that they only listen and then write down the symptoms, that they are not guiding the patient at all. But guiding always happens, whether the clinician is aware of it or not.

My feeling is that in the future we will have a way in which this particular dialogical dimension will be incorporated. I think that there are psychotherapies that developed a lot of techniques to manage this, but basically these techniques have not been incorporated in mental description. Basically, psychopathology has the possibility of doing it nowadays.

F. Di Fabio. I read "The history of mental symptoms", which is a beautiful book. In that book the mental symptoms are enlisted following the Faculty Psychology.

I would like to ask: is the choice to classify mental symptoms in that way simply because it was in that way that they were classified in the 19th Century, or is that kind of psychology still valid?

G.E. Berrios. Thank you, this is an important point. It would have been impossible to write a book on the history of mental symptoms without organizing the chapters in the traditional way.

One member of the Vienna Circle, Neurath, used to say that if you want to change things, you should do it as somebody repairing a boat in the high seas, plank by plank and never all at the same time. And I agree with that, I think that the revolutionary aspect of that book is the way mental symptoms are conceptualized, while the way they were organized in chapters is not. Because, would have I introduced a new classification of mental functions, this would have been absolutely unintelligible.

This is one explanation. And the second explanation is also more important. That book originally was over 1000 pages. The first part was the history of mental symptoms and the second one was the philosophy of mental symptoms. But the editor of Cambridge University Press recommended that the book was too big and he said "Why don't you split the book? We will publish the historical half first". I mentioned in the introduction that that was the case, that it was only the first half of the book I had written, and that the other was on the concept of mental symptom. And that book is appearing only now, it is entitled "Towards a new epistemology of psychiatry" and I had to update it because since 1996 my thinking has progressed.

T. Fagioli. Since you met Gadamer, I would like to know if you had the opportunity to talk with him about mental symptoms and mental illness. And also what do you think of Gadamer's contribution and whether he had an influence on your work.

G.E. Berrios. We talked when he wrote his book on Health and Medicine. The main contribution of Gadamer was in the dialogical situation, the idea that you have prejudices, that you already have a view of things, but that you can change them through the negotiation. You are in that negotiation, basically, and you have a different belief or view.

One of the important things about Gadamer was that he did not have a negative view of the prejudices, and that is absolutely crucial. Everybody had prejudices against prejudices but he felt that we have prejudices which are simply judgments before, and we correct them as we go on, and that is part of the negotiation.

P. Gaetano. I would like to know what, in your opinion, transforms a biological signal into a mental symptom.

G.E. Berrios. Well, what does it, it is not the sensation that the individual has as it is, but the envelop, the way in which it is configured. In order for us to speak about something we need to bring a sensation within systems of thought, and these into words, as Austin used to say. This process has a lot of functions but the essential function is to convey an idea, but that idea has been processed quite a lot. Normally for a sensation to become information it needs to be processed, it needs to be put into words, it needs to be culturally configured.

R. Proietti. But this apply also to normal thinking. What does it makes of this mechanism a symptom?

G.E. Berrios. Yes, absolutely. I think that mental symptoms occur within the processes that we all use. It is to say that normally we have certain templates which allow us to deal with sensations which we had before. We don't have a distinct system for symptom formation, it is the same mechanism, it has to be the same. It is not separate, it is part of being a human being.

R. Proietti. Perhaps it might be reframed as an individual way to elaborate and confer meanings to a situation.

G.E. Berrios. Yes, that is the consequence of it. Mental symptoms are very personal constructs and it is because we are all within a similar cultural context that they look very similar. But seemingly for me may mean something different for you.

R. Proietti. Yes, and psychiatry is a cultural construct. However, there is a circular relationship between psychiatry and culture. I would like to know what do you think about some constructionist views, like Ian Hacking's looping effect, i.e. the impact on the patients of the fact that they are receiving a diagnosis. Can you comment on the influence, in the dialogical situation, of the fact that the patient is receiving a reformulation of what he feels in terms of symptoms, of disease, and not in terms of personal construction. In your opinion how much does it influence the outcome?

G.E. Berrios[1]. Hacking's notions of "human kind" and "looping effect" constitute an effort to escape the dichotomy "natural kinds" versus "abstract kind" in which the concept of mental symptom and disorder have been trapped for a long time. In effect, human kind constitutes a third type of kind and the looping effect is a rehash of the old Mertonian concept of "self-fulfilling prophecy".

The Cambridge group tries to get away from these partial solutions by proposing a model of symptom-formation. Hacking is not a psychiatrist and he seems to accept (personal communication) the conventional view that mental symptoms are the expression of disturbed brain networks, simpliciter.

Our views are different. We believe that mental symptoms are veritable mental actions, are the result of configurational acts that patients perform on the material or information that at some point invades their awareness. This material can be the result of dysfunctional brain networks but also the result of symbolic conflict generated by difficult familiar and social relationships. We just do not know what is the proportion of each in clinical practice and it is urgent to find out for each type requires a different therapeutic approach.

Both types of information (biological and semantic) are configured by means of formats or templates that we all have in our cultural repertoire. These templates are no different from those that we use every moment of the day to configure (mostly non-consciously) the enormous amount of information (sensory and otherwise) that bombards our awareness. The information that is configured as mental symptoms is different from the every minute information because it tends to be new and strange. This is particularly so during the first episode of mental disorder. This creates perplexity in the sufferer.

It is at this moment that the "constructionist" process of our model is seen at its best. If the in-

dividual does not have specific configurators or templates to deal with the new information (say in a situation when the information, which is pre-conceptual and pre-linguistic, has not been met with before) he will resort to standard templates, those which he has learnt from the culture in which he lives.

In this sense, we believe, that "culture" (whatever that complex concept may mean) via standard templates, becomes the mechanism whereby mental symptoms and disorders are replicated in persons suffering from mental disorder. In other words, the invariance or stability that we detect in psychiatric objects (and which allows for their diagnosis and classification) may result not from the fact that these objects originate in the same part of the brain but from the fact that the information coming into their awareness is configured by cultural templates that impresses on them the same shape.

I am not denying that in some cases (like organic hallucinations) the invariance of the complaint is determined by the neurobiological specificity of the network that generates it. What I am saying is that in other cases (for example in schizophrenic hallucinations) the invariance may have cultural origin. As you can understand, this is a major departure from the current view that does not see any difference between organic hallucinations (as produced, say by drug intoxication or electrode stimulation) and psychotic hallucinations as seen in schizophrenia or severe psychotic melancholia.

1: Editor's note. In order to preserve the informal and dialogical spirit of the evening we have been as much conservative as possible with the original talk. Only the last answer has been changed, because due to a misunderstanding in the translation process, prof. Berrios' reply was about the interaction between patients and not a commentary to Hacking's idea of mental disorders as interactive kinds.
The new answer has been added in November, 2013.
The original answer about interactions between patients was the following:
G.E. Berrios. Well, the dialogical interactions between patients are absolutely important but they have not been studied a lot. You know, in medicine (and in psychiatry, where we borrowed the medical model) the negotiation takes place between the expert and the patient. The negotiation between patients and the way patients affect each other and re-conceptualize their concerns has been very rarely analyzed properly. There are some interesting accounts, for example the ménage of hysterical patients that Charcot used to have. There were 8 or 10 patient together, and they used to train each other, for example the trained girls would say to the new admitted patient "Look, you don't have to do the arch in this way, Charcot likes this other way". So, this was a cultural way to shape symptoms, and I suspect that in many other symptoms there is such a cultural influence.

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