AAPP Association for the Advancement of Philosophy and Psychiatry

Newsletter

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From the Editor

I will leave it to others to describe the pleasures and triumphs of the Spain conference. Let me mention only two of my many lingering memories. The first: a panel I chaired with presentations by Otto Doerr-Zegers ("The Phenomenology of the Body in Depression and Schizophrenia"), Victoria Allison-Bolger ("I am not myself—Madness and Personal Identity"), and Louis Sass ("Solipsism and the Yearning for a Private Language: Wittgensteinian Reflections on Schizophrenia"). The first two so thoroughly reflected the Continental and Anglo traditions that I questioned whether either understood what the other was talking about. And then Sass, with his blend of phenomenology and Wittgenstein, stepped forth with a synthesis to the thesis and antithesis that preceded him. Here indeed in my panel was a microcosm of the contemporary world of philosophy/psychiatry. The second memory: wandering the backstreets of Malaga with George Agich on a sunny afternoon after the end of the conference, browsing at the outdoor cafes, and finally joining up with Emilio Mordini, Martin Heinze, and others of the German contingent for a feast of wine and tapas at a local restaurant. A fine end to a fine conference!

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What is one to make of the brouhaha over the exhibit, "Sigmund Freud: Conflict and Culture," planned by the Library of Congress for the coming autumn. Following a petition of 50 prominent signatories the Library postponed the exhibit, citing funding problems. Although the petition only asks for a more balanced exhibit, claiming that the current advisory board is too one-sidedly pro-Freudian, it is apparent that the petition organizer, Peter Swales, the historian who has build a research career on the question of whether Freud had an affair with his sister-in-law, would prefer total cancellation of the project, which he has declared "completely one-sided and highly partisan (toward Freud)..." (*Clinical Psychiatry News,* Feb. 1996*)*. What is less clear is whether the majority of signatories, among whom are numbered such luminaries as Oliver Sacks, Gloria Steinem, and Freud's granddaughter, Sophie Freud, are in agreement with Swales' design or have been hoodwinked by him into signing the petition. While the organizers continue to insist that the problem has only been one of inadequate funding and that the exhibit will indeed take place in the fall of 1988 (*Clinical Psychiatry News*, April, 1996), the fate of the exhibit remains unclear. (See also *Lingua Franca*, Nov./Dec., 1995, for a sympathetic treatment of the petition.)

This successful campaign to sideline the Freud exhibit is striking in at least two ways: as an example of the increasing vulnerability of the Smithsonian and the Library of

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President's Column

God apparently watches over young children, fools, and organizers of international meetings. The relatively modest goal of bringing together AAPP and the Royal College of Psychiatrists Philosophy Group blossomed into a full-fledged international meeting that exceeded my own rather guarded hopes. To say that the meeting in Benalmadena, Spain, February 28-March 2, 1996 was an *international congress* however misleads. Actually, the meeting was a more congenial (120 participants) *working conference* of individuals actively conducting research in various aspects of philosophy of psychiatry. It afforded a remarkable opportunity for the active exchange of ideas and for viewing the breadth and depth of work in philosophy and psychiatry. Many participants told me that the meeting in Benalmadena was the first professional conference at which their own research interests found a comfortable niche. The meeting by all reports was collegial and worthwhile.

Participants expressed enthusiastic interest in the organization of another international meeting be planned for the not too distant future. Another topic discussed was the prospect of arranging bilateral meetings either in the US or abroad. Colleagues from Australia, France, Germany, and Italy indicated their interest in pursuing cooperative projects with AAPP. A number of initiatives are underway that I hope to be able to report on in the near future. Beside the substantive and intellectual quality of the meeting, it is remarkable that AAPP's commitment to develop this field is recognized abroad. The organizers of the meeting are currently reviewing papers for possible inclusion in a proceedings volume. I hope to be able to report on the proceedings volume in a future Newsletter.

The meeting opened with keynote addresses by Jonathan Glover, "Explanation: Human and Scientific," and Kenneth Schaffner, "Behavioral Genetics, Psychiatric Genetics, and Explanations of Mental Disorders," which set the tone for the meeting. Both papers featured clearly articulated and incisive analysis of fundamental questions and issues for philosophy of psychiatry. Plenary sessions were filled with papers drawn from each of the countries (19) represented at the meeting and parallel sessions meant that there was no time for enjoying the Costa del Sol.

There is no way to fairly report on the many sessions at the meeting, but a listing of session topics can give readers of this Newsletter a good idea of the diversity and breadth of interests represented: narrative and interpretation theory, personal identity, conceptual issues, self deception, intersubjectivity and interpersonality, mind body relations, conceptual models in psychiatry, concepts of psychiatric disorder and mental illness, causality in psychiatry and psychotherapy, theoretical issues in psychotherapy, suicide, ethical dilemmas, the language of psychiatry, diagnosis and classification, phenomenological psychiatry, personal identity, culture and community, and boundary questions. These topics attest to the vibrancy of current work in philosophy and psychiatry and to the common research interests that promoted highly worthwhile collegial interactions.

George Agich, Ph.D.

Letter from Sydney

In October, 1994, a group of psychiatrists met in Jeanette Martin's home in Sydney to establish a Philosophy and Psychiatry Group within the New South Wales State Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP). Jeanette Martin and Stephanie Winfield had previously (1992) organised a series of twelve seminars on philosophical topics for psychiatrists which had been well received, and were aware of the philosophy group within the Royal College of Psychiatrists. Once Stephanie had been exposed to the irresistible charms of Michael Schwartz and Bill Fulford in Paris at the First World Congress of Medicine and Philosophy, it was clear that the time was now to try to set up a more permanent philosophy group within the RANZCP.

The initial meeting attracted around a dozen people who were swiftly relieved of $25 each to cover the group's expenses. We decided to hold monthly evening meetings in Jeanette's home, starting with tea/coffee and sandwiches to revive the participants, before a 30-45 minute paper followed by an hour's discussion.

We have now completed our first calendar year of activities and it seems the group is on a firm footing. During the year we heard nine papers on topics from both the Continental and Anglo-American traditions, given by psychiatrists, philosophers and a historian, and had a dinner with Professor Grant Gillett, followed by a paper. Initially the group was a little anxious about admitting non-psychiatrists as group members, wishing first to consolidate its aims and to find an appropriate level for philosophical discussion among psychiatrist members. We now have academics and post-graduate students in philosophy as members, as well as psychiatric nurses, psychologists, and a varied bunch of psychiatrists. It is a lively mix! Our numbers have grown steadily, to the point that at the last meeting Jeanette was reduced to climbing in the window to enter her living room, such was the crowd.

With the encouragement and advice of Professor Sid Block, we are currently embarking on a new stage of development—the formation of a binational philosophy group within the RANZCP. Representatives from each Branch of the College are working as an ad hoc committee towards this, and we hope to launch the group at the College Congress in Wellington, New Zealand, in May, 1996.

We invite any members of AAPP who are visiting Sydney to come to our meetings, perhaps to give a paper! Contact Stephanie or Jeanette via phone or fax: Stephanie (02) 389-1896; Jeanette (02) 386-1758.

We enjoyed meeting many colleagues at the Philosophy and Mental Conference in Spain in February, and look forward to the continued development of philosophy and psychiatry.

Drs. Jeanette Martin and
Stephanie Winfield
Sidney, Australia

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The First International Conference On Philosophy And Mental Health
Benelmadena, Spain
February 28 - March 2, 1996
Report

One of AAPP's most important events this year, co-sponsored by the Royal College of Psychiatrists Philosophy Group, was the First International Conference on Philosophy and Mental Health, which took place in Benalmadena, Spain, between February 28 - March 2, 1996. A long desired and awaited international reunion, the meeting was conceived as a direct response to the recent upsurge of cross-disciplinary contact between philosophers and mental health practitioners on a world-wide basis. The organizers aimed to offer the many international groups and individuals working in this rapidly expanding field an opportunity to get together, and also to provide an opportunity for the exchange of ideas and experience, the presentation of new research, and the discussion of new teaching initiatives.

The main organizers of the Conference were the Royal College of Psychiatrists Philosophy Group in the UK (KWM Fulford) and the Association for the Advancement of Philosophy and Psychiatry (G. Agich) in the USA. However the organizing committee included representatives from other groups concerned with this field from elsewhere in the world, including Australia and New Zealand, Germany, Italy, Sweden, Norway, Denmark, Finland, Scotland, France and Romania.

The organizers' choice of site was the Hotel Triton in Benalmadena, Spain. (We had initially hoped to meet midway between the USA and the UK—this was as "midway" as we got!) Happily, this placed the Conference in the wonderfully picturesque landscape of the Costa del Sol, where the mountains meet the Mediterranean Sea in a combination of green and endless marine-blue spotted by the incredible white of traditional Andalusian architecture. The schedule of the Conference was busy, starting with two substantive and theme-setting Keynote Addresses by Jonathan Glover ("Explanation: Human and Scientific") and Kenneth Schaffner ("Behavioral Genetics, Psychiatric Genetics, and Explanations of Mental Disorders"), and then proceeding to Plenary Sessions in the mornings (each offering 6 papers and followed by intellectually challenging discussions moderated by a designated chair) and Parallel Sessions in the afternoons—one of which was conducted in German. One of the most difficult tasks for a participant was to chose among the many exceptional presentations unfortunately held at the same time during the parallel sessions. However, the time spent together with experts in the field and the cross-fertilizing discussions between delegates (for which the Conference provided plenty of opportunities) created many possibilities for networking, new insights, and new friendships.

In this report, due to limited space, we will be able to present only a few of the most important papers. We hope that this selection can give the reader an idea about the wonderful atmosphere of this conference and about the diversity and depth of subjects presented by world-class investigators.

It seems fit to begin with an analysis of phenomenology and current and future trends in its relationship with psychiatry as presented by Michael Schwartz and Osborne Wiggins (AAPP) in their paper: "Phenomenological Psychiatry in the Next Century." Modern psychiatry, represented by Kraepelin, and phenomenology, as developed by Husserl, began around the same time and shared a common goal: detailed descriptions of human experience. The relationship between the two fields has undergone multiple transformations, but at its core, the phenomenological approach continues to emphasize to psychiatrists the concrete situatedness of persons through embodiment, culture, and history. Schwartz and Wiggins proceeded to identify three main future directions for cooperation between phenomenology and psychiatry: (1) the development of a philosophical anthropology through which mental disorders can be comprehended, (2) an

appreciation that multiple methods are required to explicate human existence (in illness and in health) in detail, each with its own strengths and weaknesses, and (3) the furnishing of examples of unusual human experiences which can stimulate and inform clinical and phenomenological investigations.

In his masterful paper on "Interpersonality and mind-body correlation", Bin Kimura (Japan) showed deep interconnectedness in the relationships between oneself and others and also in the correlations between mind and body. Besides the Husserlian concept of a "public" intersubjectivity (which is opened to anyone who may participate in it), there can also be a closed, "private" intersubjectivity accessible only for those who are intimately concerned (illustrated by Merleau-Ponty as "intercorporéité"). Ultimately, the "problem of other minds" is a biological problem as well as a philosophical one, with important consequences for psychiatry and psychopathology as well as for ordinary human discourse.

Sandro D. Gindro (Italy) identified multiple philosophical roots for psychoanalytical thought: Positivism and Indian philosophy, neoplatonism and the metaphysics of the Renaissance, phenomenology and axiology, and linguistics. The resulting philosophy is a practical one (in Plato's sense), and for this reason a philosophy that can cure.

Jean Naudin's (France) "What hearing voices means: towards a narrative analysis of hallucinatory epoché," focused on the phenomenological significance of auditory hallucinations in schizophrenia. The paper identifies three important meanings of the voices: 1) the internal constitution of self by others, 2) the narrative constitution of self into stories, and 3) the narrative basis for understanding—all "characters" are involved together in these stories.

Jennifer Radden (USA) explored the function of interpersonal trust as an important moral, social and mental health norm in the context of DDPT (Delusional Disorder Persecutory Type) in her paper "Mental Health Norm Undergirding DDPT." This disorder, she contended, shows that disability and distress are not the sole justifiable diagnostic criteria for mental disorder, since DDPT can occur without either. For Radden, judicious trust is a central moral and epistemological norm that rests on a number of social and relational capabilities such as empathic understanding. Patients with DDPT may lack disability or distress yet have profound problems with judicious trust. In order to continue to affirm the disorder status of DDPT, we must acknowledge this additional norms.

Louis Sass (USA) presented a paper on "Solipsism and the Yearning for a Private Language: Wittgensteinian Reflections on Schizophrenia." After showing the importance of Wittgenstein for a phenomenology of schizophrenia and related conditions and analyzing Wittgenstein's famous meditations on the notion of a "private language" Sass turned to the French poet, playwright and essayist Antonin Artaud—an extremely schizoid individual who eventually was diagnosed and hospitalized with schizophrenia. A close phenomenological analysis of Artaud's descriptions of his own experience demonstrates that his difficulties (akin to those experienced by many schizophrenic persons) can be understood as consequences of an especially intense yearning for the impossible goal of a private language.

The "Phenomenology of Body in Depression and Schizophrenia" by Otto Doerr-Zegers (Chile), showed that psychopathology has not yet been very concerned about the bodily aspects of mental illness despite the fact that multiple bodily changes are often seen. The author especially referred to the "lived body," the body which I am, not to the body which I have. The lived body shows in turn at least two faces: the body as support of the experience of oneself and the world, and the expressive body in permanent relationship with the world and with the others. Starting from a phenomenology of corporality, the author addressed the fundamental question of the disturbances of the lived body in schizophrenia and major depression. He showed that in depression there is a profound deterioration of the body as support, which is experienced by the patient as a process in which the body gets more and more opaque, interfering with the natural condition of human existence of being open to the world. The lived body in schizophrenia as presentation in front of the other loses its position and is invaded by them, so that the balance between watching and being watched is displaced to the latter. Consequently, the space occupied by the body may be reduced even to the degree of a fetal position in some severely catatonic and autistic patients.

Among the multitude of interesting papers presented during the German language sessions, space only allows us to mention two of them. "The Challenge of Phenomenology in Psychiatry" by Wolfgang Blankenburg (Germany) contrasted phenomenology in Jaspers' sense with phenomenology in Husserl's sense. The former is too simple and the latter too complex for clinical psychiatry. According to

ADVANCE NOTICE/
CALL FOR ABSTRACTS

AAPP NEW ENGLAND REGIONAL MEETING

Saint Joseph College
West Hartford, CT
Friday, January 17 -
Sunday, January 19, 1997

Theme:
Imagination and its Pathologies

Invited Speakers:

Edward Casey, Ph.D., Professor of Philosophy, SUNY, Stony Brook, NY

Amedeo Giorgi, Ph.D., Professor of Psychology, Saybrook Institute, San Francisco

Richard Kearney, Ph.D., Professor of Philosophy, University College Dublin

Ethel Person, M.D., Professor of Clinical Psychiatry, Columbia College of Physicians and Surgeons, Training and Supervising Analyst, Columbia University Center for Psychoanalytic Training and Research

Deadline for abstracts of 600 words is July 15, 1996. For full information contact any of the following:

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James Phillips, M.D.
(cf masthead)

Blankenburg, it is considered useful to take into account French phenomenology and the phenomenological concepts of the social sciences. After listing multiple equivocations in the term "phenomenology," the author wondered if it makes sense to insist on retaining it.

We would like to bring this report to an end by mentioning "The Importance of Intuition in Psychiatric Diagnosis" by Alfred Kraus (Germany), which explains some of the problems with classification due to deficits at the descriptive level—a level at which the operational diagnosis of DSM-IV puts great emphasis. A fixation on descriptive categories can only lead to new, kaleidoscopically ever-changing groups, a problem already described by K. Schneider and K. Jaspers. What is really required is process that will help translate the rich intuitive experience of the psychiatrist into scientific language and thereby introducing it into diagnosis and classification schemas. This is only possible through the development of categorical, paradigmatic frames, facilitating not only new experiences, but making them easier to describe. Diagnosis appreciated in this manner can be a true source for progress in psychiatry and in other scientific disciplines as well.

Before closing, again a note of thanks for the organizers and participants, and we will be looking forward to the second International Conference on Philosophy and Mental Health.

Cristinel Coconcea, M.D.
Case Western Department of Psychiatry
Cleveland, Ohio

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AAPP Program at APA

Report

The AAPP sponsored a program on "The Relational Self as Goal of Therapy." at the annual meeting of the Eastern Division of the American Philosophical Association in New York at the end of December. Philosophers Jennifer Radden and Janet Farrell-Smith, both of the Philosophy Department of the University of Massachusetts in Boston, shared the podium with psychoanalyst Dr. Doris Silverman, Clinical Professor in the NYU Postdoctoral Program in Psychoanalysis and Psychotherapy and a training analyst fellow, teacher, and supervisor at the Institute for Psychoanalytic Training and Research (IPTAR).

Jennifer Radden opened the meeting by describing the "relational turn" in recent thought, which has fostered the recognition that models of self are socially constituted. Because the kind of person one wants to become often shapes therapeutic engagement, particularly with less severely disturbed patients, changes in the model of self will also show up in the goals that guide therapy and define the criteria by which its success is understood. However, the relational model of self presupposes a range of psychological claims, moral and political values and mental health norms that require close analysis. Radden distinguished three such claims as salient: (1) we are more relational than has hitherto been supposed; (2) metaphysically, the self is constituted by its relations with others, and (3) we ought to value our relationality.

Doris Silverman urged a pluralist, eclectic approach that would balance the relational model with more objectivist methods. She enriched the discussion with a sensitive account of how relational issues arise in the therapeutic process and in the lives of her clients, while insisting on the importance of the uniquely private self experience emphasized by theorists like Arnold Modell. Silverman described recent developmental studies of infant-mother attachment and the complex interactive exchanges that produce the mature relational self.

Janet Farrell-Smith explored the metaphysical and anti-metaphysical implications of the claim that selves are socially constituted in her paper on "The Theory of the Relational Self: Metaphysical or Psychological." She pointed out that the sorts of subjectivity featured or made invisible in a given therapeutic approach can derive from explicit or implicit theories of selfhood. She therefore asked whether the theory of a relational self is a psychological or psychoanalytic theory about how to accurately describe ? and what to value? Or is it a meta-level theory about what, at bottom, the self amounts to as an entity (or not) in the world and in subjective awareness? Farrell-Smith illustrated her distinctions using examples from theorists such as Seyla Benhabib, who offer gender role criticisms of classic political theories; presumption of a male developmental model.

Although it met at the same time as a session on Jacques Lacan sponsored by the Association for the Philosophy of the Unconscious, the meeting drew an audience of about thirty philosophers and clinicians who offered intriguing and fruitful questions and comments for the panel of speakers. A lively discussion developed over whether relationality opposes autonomy or fosters its emergence, and over how competing conceptions of the self bear upon particular clinical cases. The audience challenged the anti-metaphysical models of self outlined by Janet Farrell-Smith, cited cross-cultural research on attachment and discussed the way disorders like autism can imperil the achievement of relationality and attachment.

Jennifer Radden, Ph.D.
J. Melvin Woody, Ph.D.

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Essay Review

Philosophical Perspectives on Psychiatric Diagnostic Classification, edited by J.Z.Sadler, M.D., Osborne P. Wiggins, Ph.D., and Michael A. Schwartz, M.D., Baltimore: Johns Hopkins University Press, 1994.

One of the articles in *Philosophical Perspectives on Psychiatric Diagnostic Classification* (PPPDC) contains the following statement: "In DSM-III-R post-traumatic stress disorder is 'more severe and long lasting when the stressor is of human design...,' an acknowledgment that the *meaning* of the stressor is critical for the course of the disorder. It is simply easier to explain, that is, to cope with, a natural disaster than one resulting from human neglect or intent" (Mishara, 145). Most of the articles in this excellent collection aim to show 1) that the philosophical assumptions embodied in DSM-III-R are such as to subvert every effort to include the meanings human beings find in experience as a necessary factor in diagnosing, understanding, and treating mental disorders; 2) that, as the above quotation shows, DSM-III-R does not succeed in excluding meaning, because meaning cannot be excluded when human psychic phenomena are under consideration; and 3) that the consequences of the attempt to exclude meaning have been and will continue to be disas-

trous both for psychiatry and patients who are psychiatrically diagnosed and treated.

Each of the articles considers theoretical, empirical, and clinical aspects of these issues. With the exception of the initial, informative "historico-philosophical" overview of "Psychiatry and its Nosology" by Edwin R. Wallace, IV, the articles are arranged in four broad categories: I: Methods; II: Psychopathology; III: Values; and IV: Future Prospects and Alternatives. There is, however, considerable overlapping of these categories within the articles themselves. Let me say at the outset that every article in this volume upholds high scholarly standards, is well-written, original, and challenging. Indeed, the volume is now indispensable for anyone working in the field of psychiatry, and for anyone interested in the philosophy of psychiatry or clinical psychology. In this review, I will not do justice to all fourteen of the articles. Nevertheless, I hope to both provide an overview through an examination of representative perspectives, and suggest a direction in which the project of a philosophical critique of DSM-III-R might move into a constructive or reconstructive phase. In the course of carrying out these tasks, the inner connectedness of the major issues dealt with in the articles will become apparent.

The authors and editors attempt to show that there is considerable internal consistency in the points of view represented in the volume as a whole. Many of the articles contain favorable citations of others in the volume. Indeed, inasmuch as all of the authors critique DSM-III-R and its presuppositions, there is a shared, broadly humanist stance that provides unity of perspective. What is less obvious, however, is that there are significant differences in the various points of view, which, when clarified, sharpen the issues in a way that should help to resolve those differences. In this review, I will reconstruct the nature and implications of these differences.

In their useful introduction (1-15), the editors explain the historical relation of the work of the philosopher Carl Hempel to the creation of DSM-III-R (and DSM-IV, since the authors of all of the articles seem agreed that no great changes will be made in the new version), and the book contains Hempel's seminal 1959 paper "Fundamentals of Taxonomy" as an appendix. As is now well-known, the creators of DSM-III-R sought a diagnostic schema consistent with the operational model proposed by Hempel. The most extensive discussion of Hempel's philosophical assumptions is provided by the philosopher Margolis in his "Taxonomic Puzzles." This is followed, in part I, by two articles, both of which propose an alternate model derived from philosophical phenomenology. In addition, in part II, there is another article inspired by philosophical, i.e., Husserlian, phenomenology: Peter Caws' "Subjectivity, Self-Identity, and Self-Description: Conceptual and Diagnostic Problems in Autism, Schizophrenia, Borderline Personality Disorder, and the Dissociative Disorders." The first of the phenomenology articles is "A Phenomenological Critique of Some Commonsensical Assumptions in DSM-III-R," by Aaron Mishara. The perspectives of these two researchers, Margolis and Mishara, both of whom make a devastating critique of the Hempelian legacy of DSM-III-R, are quite divergent, and thus reveal that those who oppose positivism do not agree as to the best alternative. Of great interest is the manner in which the results of studies reported in some of the other articles lend support to the perspectives of either Margolis or Mishara.

Margolis presents a lucid and powerfully argued exegesis of the reasons why the positivistic unity-of-science model of scientific explanation, the Hempelian 'covering law,' 'hypothetico-deductive,' 'inductivist,' or 'verificationist' model, has been rejected by both scientists and philosophers of science. A wide consensus exists that, contrary to the assumptions of inductivism, all observations are theory-laden; that universal propositions in principle cannot be verified; that .induction itself cannot be justified; that positivism must be rejected; and that indispensable concepts, e.g., mind and body, are not, and cannot be, operationalized. Consensus on these points indicates that the positivistic, Hempelian view is incorrect, and, when applied to psychiatric classification, has resulted in incoherences and errors. However, this is not all that is presented by Margolis.

Most significantly, Margolis' view, contrary to that of Mishara, is that psychiatric diagnostic classification *cannot be scientific*. Margolis states, for example, that "...the best prospects for a scientific taxonomy appear to depend on the adequacy of something like the unity-of-science model," and that "..the reforms pursued from III to III-R...could never lead to a fully scientific taxonomy unless we could be sure of the validity of a strong inductivism...Such an empiricism now seems hopelessly outmoded" (118). Thus, for Margolis, the Hempelian model really is the best scientific model, certainly for psychiatry, and the fact that it has been rejected by scientists and philosophers of science is taken to mean that *there can be no scientific taxonomy for psychiatry.* Margolis buttresses this point with extensive discussion of the cultural and historical relativity of psychiatric diagnostic categories. Moreover, Margolis presents an interesting analysis and critique of the DSM-III-R descriptions of schizophrenia and schizophreniform disorders. Since he recognizes the intentional nature of psychic life, and recognizes that this factor cannot be excluded from any attempt to understand these disorders, Margolis agrees with those who advocate a hermeneutic, rather than scientific, methodology for psychiatry. In fact, it seems that Margolis himself is an advocate of strong physicalism as the necessary perspective of science, and thus would believe that only the natural sciences can be sciences at all; this, therefore, excludes psychiatry, which cannot do without the intentional view of human thought and action, from being a science.

Aaron Mishara, presenting the perspective of philosophical, that is Husserlian, phenomenology, holds, on the contrary, that there can be a scientific classification system for psychiatry, one which, while fully recognizing and incorporating the phenomenon of cultural and historical change, nevertheless, on phenomenological grounds, rejects a relativistic stance. That is, for Mishara, as for Husserl, there can be a science of subjectivity. This view is reflected in the quotation from Mishara presented in the opening lines of this review. That the meaning of the stressor, whether it is a result of natural disaster or of human intent, "is critical of the course of PTSD" (as stated in DSM-III-R), is taken by Mishara to hold for all persons at all times and thus as evidence that there are universals *of meaning* operative in human experience, i.e., human subjectivity, however contrary this may be to the positivistic philosophical framework of DSM-III-R. Moreover, for Mishara these universals of meaning can be introduced into psychiatric classification, thus providing classification with a scientific foundation. Mishara describes this advantage when he states that the phenomenological approach shows that "meaningful structure can be formalized and arranged into a typology according to basic phenomenological categories of the subjective experience of time, space, embodiment, and the relationship to others and self..." (131). For example, Mishara maintains that "the relation to self is also bipersonally structured in that one transcends one's past self through envisioning new possibilities" (139). Again, it

is crucial to understand that Mishara intends here that bipersonality be understood as a non-relative, universal structure, though this does not rule out that the content of intentional experiences of bipersonality can change culturally and historically, etc. But, that content is relative *to* the universal structure that informs it and provides its functional capacity. Mishara goes on to illustrate the clinical value of the bipersonality structure:

It is also this structure, however, that in part makes possible, for example, depersonalization disorder; the ability of the anorexia nervosa patient to consider her or his body image and interoceptive stimuli primarily from an external point of view; or even the schizophrenic hallucinating of voices commenting on the subject as if issuing form an other. In each case, self-transcendence is compromised in the ongoing exchange between self and other." (139)

It is important to point out that the grounds on which Margolis rejects a scientific psychiatry are *certain claims about the nature of experience, of subjectivity*; i.e., that while human subjective experience is intentional in character [the view pioneered by Brentano and Husserl], at the same time its structures cannot be formalized because they have no universalizable, non-relative characteristics. This is the point of disagreement with Mishara who, following Husserl, believes that the structures of subjectivity *can* be formalized. Thus, it is interesting to look at some of the findings reported in other articles in the collection in terms of whether or not they support Margolis' or Mishara's perspective.

Several of the articles report on and interpret studies on patients' experiences of hallucinations. The most extensive discussions occur in two articles in Part II: Psychopathology: M. Spitzer's "The Basis of Psychiatric Diagnosis," and G.L.Stephens and G. Graham's "Voices and Selves." Significantly, both articles maintain that there is a preponderance of evidence against the view that auditory and visual hallucinations are distortions in perception, i.e., that there is a problem affecting the hallucinating patients' perceptual systems whereby they perceive actual sounds and sights without external stimuli. The evidence cited in both papers leads to the conclusion that patients are quite capable of differentiating between their actual sensuous perceptions and their hallucinations, i.e., they are aware that these are different experiences. These findings are consistent with the standpoint of philosophical phenomenology according to which, since hallucinations are not perceptions of outer objects, they cannot in principle be experienced as such. These findings militate strongly against the widely expressed "common sense" view that people who hallucinate believe that their hallucinations are "real," and that they cannot differentiate between their hallucinations and actual perceptions of outer objects. (It is, by the way, interesting to reflect on the origin and tenacity of this common sense view. My suspicion is that common sense wants to insist on the utter irrationality and inexplicability of psychotic phenomena so as to draw an absolute border between normal and abnormal: (How should I know how psychotics see things that aren't there? I'm not nuts!—as if to understand mental disorder is to succumb to it!) Incidentally, Spitzer finds this view embedded in DSM-III-R's definition of hallucination as: "A sensory perception without external stimulation of the relevant sensory organ. A hallucination has the immediate sense of reality of a true perception...." (166). Spitzer points out that some of the research that counter-indicates this definition long predates DSM-III-R! Most importantly, the common sense view is also the view most consistent with the Hempelian-positivist position, for that position cannot encompass the notion of the intentionality or directedness of psychic acts, i.e., of acts that originate in the subject where the subject is viewed as irreducible to physical entities.

Granted their agreement on these points, Spitzer and Stephens & Graham go in different directions. Spitzer adopts a version of the phenomenological attitude which he presents as the realization that every psychic act involves a perspective on the world. He then raises challenging philosophical questions regarding the philosophical foundations of DSM-III-R. He points out that the DSM-III-R definition of hallucination assumes that 1) we can determine that the hallucinating subject is not receiving sensory stimulation vis-a-vis the hallucination; 2) that we know what is the boundary between internal and external; 3) that we know what is "the immediate sensation of reality" and who has such a sensation, when, and how often; 4) that we know what a "relevant sense organ" is; and 5) that we know what we mean by "physical." "We do not know whether physics really matters; and in clinical settings, physics certainly does not matter. In physics, the notions of red, bitter, or loud do not occur. Moreover, what are we to make of the notion of an *independent* physical reality--does this imply that there could be a dependent physical reality?" (168). Spitzer goes on to make similar analyses of the DSM-III-R treatment of delusions and mood congruence. Finally, he argues against the positivists' attempt to separate discovery (clinical work) and justification (evidence and scientific formalization): "...basic psychiatric concepts should take into account the hermeneutic nature of the diagnostic process...DSM-III-R falls short of its own standards of being etiologically atheoretical and minimizing inference" (177). Spitzer also presents a complete statement on hallucinations as a worked-out, more "open" (170) alternative to the DSM-III-R statement. (Mishara denies that DSM-III-R is atheoretical and, most importantly, maintains that its classification system reflects a thoroughgoing behaviorism with all of its theoretical assumptions. This suggests that Hempel and the creators of DSM-III-R, whether consciously or unconsciously, *made no distinction between atheoreticism and behaviorism*!)

Since Spitzer emphasizes the hermeneutic process of the clinical work of discovery, it might seem that his article supports Margolis' view that rejecting positivism means accepting a non-scientific conceptualization of psychiatric classification. Yet Spitzer's viewpoint as a whole is not so clear cut. While he recognizes the hermeneutic nature of *discovering* the diagnosis, he believes this should be clearly distinguished from the task of *justifying* or validating the diagnosis. Moreover, while pointing out that DSM-III-R makes a plethora of philosophical assumptions, Spitzer still maintains that the definition of psychiatric symptoms "should be as little theory driven and as little inferential as possible..."(177). However, the hermeneutic perspective is different from this in that it affirms that all perspectives are just that--perspectives, and are driven by theories that are historically, culturally, and individually relative, so that whatever criteria are established for minimizing theory dependence are themselves hermeneutically relativized. It seems then that there are reasons to suggest that Spitzer's perspective is more akin to Mishara's in that he holds to the possibility that phenomenological description can yield universalizable (i.e., without unjustifiable bias) evidence. Spitzer's approach of relentlessly pointing out the non-evidential assumptions and inferences built into DSM-III-R suggests the possibility of an attitude that can transcend or at least be directed toward transcending the tendency to make assumptions unwarranted by the evidence at hand, i.e., that we are not hopelessly mired in relativism.

Given that many patients with auditory hallucinations recognize that they are not hearing the voice, in "Voices and Selves" Graham & Stephens focus on pro-

viding an explanation of the "alien" character of voices, i.e., on how it is that such patients nonetheless regard the voice "as a genuine communication from another person." These researchers accept what they refer to as the misattributed act theory (MAT) of voices, the theory that "voices involve genuine speech production and awareness of speech production, but the subject misattributes the relevant speech acts" (1182). However, Graham and Stephens maintain that MAT does not provide an explanation of *why* subjects misattribute their own inner speech. In providing such an explanation, the authors draw on their earlier discussion of the analytic philosopher Dennett's concept of "intentional stance," which means that the subject is viewed as the bearer of beliefs, desires, and other attitudes towards self, others, and objects. Graham & Stephens maintain that "voices" are the product of disturbances in the subjects' sense of self:

An episode of inner speech which the subjects refuse or fail to acknowledge as an expression of their own attitudes and intentions may nevertheless seem quite intentional to them.... A young mother, concerned about her child's welfare and her own maternal responsibilities, may find the utterance "Bad mother"...occurring in her consciousness. She does not acknowledge in herself the sorts of beliefs and desires which would naturally find expression in such utterances... Nonetheless, it is hard for her to dismiss this verbal episode as random verbal imagery. It seems to betray an agency...Thus, she may have the strong impression that she is hearing another speak..(188)

Graham and Stephens conclude that voices are not, as DSM-III-R would have it, perceptual disturbances, but are, rather, "disturbances of active self-consciousness" that are "best understood by picturing persons as self-conscious intentional systems, actively involved in interpreting their own mental life" (192).

Graham and Stephens give little indication of their owr. general stance on epistemological and ontological issues, although clearly they are vehemently opposed to the positivist elements in DSM-III-R. They also seem strongly to favor including in psychiatric diagnosis and treatment the crucial factor of patients' own views of the meaning of their experiences. To make my point then, there is nothing at all in "Voices and Selves" that would rule out, and much that would promote, Mishara's notion that "the relation to self is also bipersonally structured in that one transcends one's past self through envisioning new possibilities" and that in "hallucinating voices commenting on the subject as if on another," subjects' "self-transcendence is compromised in the ongoing exchange between self and other" (139). Nor, it seems to me, is there any statement by Graham & Stephens that suggests they would reject the notion of bipersonality as a universal structure of humanness.

Thus far, I have not pointed out any articles in PPPDC that support Margolis' hermeneutic view. One such article is Aviel Goodman's "Pragmatic Assessment and Multitheoretical Classification: Addictive Disorder as a Case Example" (in Part IV). Goodman is quite explicit in presenting his philosophical stance. He begins by outlining the classical critique of positivist empiricism that is contained in many of the papers in PPPDC. He concludes from this as follows: "An atheoretical diagnostic classification system is not only unrealistic as a claim, but also undesirable as an ideal. Psychiatry is best served by a classification system that is not atheoretical but is multitheoretical--which encourages and embraces diverse theories, precluding none on a priori grounds while holding all equally to standards of pragmatic value" (297). In his concluding remarks, Goodman maintains that his multitheoretical/pragmatic approach is "an attempt to actualize the scientific program of Habermas, as described by Hesse...'there are basically only two modes of knowledge, and the empirical and the hermeneutic both have to become self-reflective and critical....' " (311).

Goodman maintains that it is not DSM-III-R which has failed; rather, the failing is in "the ideal of atheoreticism to which it aspired," and, "DSM-III-R is a pragmatically oriented system and...a pragmatic approach is best served by a multitheoretical framework" (296). Goodman then provides as a case history of his attempt to present a multitheoretical alternative to the DSM-III-R classification of "Addictive Disorders." More specifically, Goodman proposes to bring together several disorders that are listed in separate categories in DSM-III-R, e.g., psychoactive substance dependence, bulimia, sexual addiction, pathological gambling, etc.; that is, these are disorders for which DSM-III-R has as diagnostic criteria patterns of compulsivity and loss of control, and which differ only in types of symptomatic behavior. Thus, "The proposed diagnostic modification groups together in one category several disorders and thus indicates a clinically significant relationship among them" (308). Goodman maintains that when he first proposed his modification, there was resistance to application of the term *addiction* to any behavior other than substance addiction, especially sexual addiction. In addition, Goodman marshals considerable evidence to show that there is an underlying pathological process at work in these behaviors and that they are not merely socially deviant behaviors. The author's conclusion is that, "...if atheoretical empiricism is maintained as the ideal and theory and context are viewed as necessary evils, they will be less likely to be subjected to scrutiny and hence more likely to operate covertly in ways that may undermine the pragmatic value of the system"(310). Indeed, Goodman maintains that the present classifications of the disorders listed above have failed to be of service to patients and may have negatively affected the ability of those who work with such patients to help them.

While Goodman's rejection of empiricist atheoreticism is cogent, as is his proposal for a new classification, he does not seem to have provided a cogent rationale for what he refers to as a multitheoretical approach. In fact, it is difficult to understand what Goodman is referring to by *multi*theoretical: does he mean hermeneutic and empiricist, as per Habermas? Or, does he mean any and every possible theoretical orientation? Most importantly, however, Goodman's proposal that there is a common addictive process at work in a wide variety of symptomatic behaviors can be contained within the perspective of philosophical phenomenology, which, as we have seen, seeks universal structures of subjectivity. From this point of view, it is unfortunate that a thinker as influential as Habermas has ruled out philosophical phenomenology, which is a form neither of hermeneutics nor of positivism, as a philosophical foundation for psychology. A study of Habermas' writings shows, it seems to me, a manifest failure to understand Husserlian phenomenology. This failure is evident, for example, in Habermas' (1972) *Knowledge and Human Interests*, a work in which he claims that no emancipatory interest can be found in Husserl's philosophy, a claim with as little validity as it would have if made against Socrates. Thus, while Goodman argues persuasively against empiricist atheoreticism, and presents a strong case for his proposed modification of DSM-III-R's treatment of addictive disorders, his paper fails to show the relevance of his proposed multitheoretical/pragmatic approach, especially if he sees this approach, as he seems to, as a type of hermeneutic perspective. If the multiplicity of theories reflect differing epistemological and ontological commit-

ments, these commitments will be mutually contradictory, a situation that can only be tolerated within a perspective of strong relativism. Yet Goodman gives no indication that he accepts such a relativistic perspective.

Goodman is, interestingly, not the only author in the collection who adopts the view that DSM-III-R reflects a pragmatic view of mental disorders. In his article, "Evaluative Judgment and Personality Disorder" (Part III), G. Agich maintains that,

> A pragmatic approach is atheoretical in that it is not committed to any particular theory of psychiatric disease, but nonetheless need not be completely neutral regarding etiologic explanation,...The basic point, after all, is not to explain, but to classify... Such an approach to psychiatric nosology...read[s] DSM-III-R as an effort to provide a single classification system that meets the various requirements of contemporary psychiatric practice...[which]...include record keeping for clinical and research purposes, quality assurance, reimbursement, and forensic purposes... (236)

Agich maintains that since DSM-III-R is based on a pragmatic approach to diagnosis of mental disorders, the prevalent critique of its failure to attain its goal of atheoreticism and the exposure of its inherent theoretical assumptions is irrelevant. What is more important for Agich is not the theory involvement of DSM-III-R's concepts, but rather the evaluative commitments that he believes are "far more basic and important than theory commitments as such, because theoretical commitments themselves reflect preferences regarding principles of causation, explanation, or relation" (235). For Agich, these latter principles "inevitably involve and reflect cultural, historical, and social preferences and values..." (235). To illustrate his view, Agich presents an interesting discussion of the classification "Antisocial Personality Disorder" (APD) in the DSM.

Agich objects to the emphasis on violent symptomatology for APD to the exclusion of personality traits like "exploitative or manipulative behavior that is related psychologically to aggressive antisocial behavior" (244). Agich points out that "By restricting social personality disorders to predominantly aggressive interactional patterns and criminal behavior, ...the distinction between sociocultural and economic determinations of delinquency on the one hand and psychopathology on the other is blurred..." (243-44). It does not take much reading between the lines to see that Agich is claiming that DSM-III-R's description of APD contains a manifest class bias, i.e., people in different socioeconomic classes manifest their antisocial symptomatology in very different behaviors.

Agich's basic critique of DSM-III-R is that classificatory categories are prototypes which by definition are context independent. Agich emphasizes that he agrees with those who have "a belief that psychiatric diagnosis is essentially a matter of practical ethics," but that "unlike them" he "accepts the descriptive aspect of diagnosis and believe[s] that nosology is an eminently practical and pragmatic exercise" (244). Agich here suggests that those who believe that psychiatric diagnosis is a matter of practical ethics may also have certain theoretical commitments, e.g., to a hermeneutic view, that he does not share, since he recognizes a pragmatic goal for DSM-III-R, i.e., a goal that excludes any search for a theory adequate to the phenomena. Here, there emerges a certain naivete in Agich's views, one that it seems to me casts a brilliant light on the heart of the matter.

One might ask Agich this question: doesn't his claim—that a context-dependent approach to description of APD is more pragmatic—reflect his own evaluative stance, i.e., his values? What does it mean to say that traits like manipulativeness and exploitativeness are psychologically related to criminally violent aggression? In point of fact, this writer shares Agich's concerns and values with respect to the matter at hand. But, on what basis does he privilege his view of the nature and scope of the context within which he feels diagnostic concepts must be embedded? Or, to put the issue in a more fruitful way, why is it that Agich does not ask this question: how has it happened that the DSM-III-R, which has been created according to the positivist-operational, unity-of-science model, turns out, in its "pragmatic" "contextless" way, to have also built into it racism, sexism, and classism? Could it be that classical empiricism bears within it in its very conceptual structure the prejudices of the upper class gentlemen who gave it birth? This is "pragmatism" of another sort indeed—the pragmatism of self and class interest! In the interest of clarity, let me add that I do not mean to suggest that there can be no rationale to justify Agich's (and my) values; only, Agich does not provide such a rationale nor does he give any indication that he thinks such a rationale would strengthen his position. What would strengthen his position, it seems to me, is an attempt to reconstitute it using the phenomenological method. This method is described by Mishara as one that "enables a maximizing of the subjective sources of cognition and the clinician's thematizing of the subjective experiencing of the patient....it provides a maximizing of distance with respect to the reality claims of these subjective cognitions of self and others by placing them into methodical suspension or brackets" (146).

As mentioned above, Agich maintains that DSM's classifications, at least some of them, are context-independent prototypes. O. P. Wiggins and M. Schwartz, in their Part I article, "The Limits of Psychiatric Knowledge and the Problem of Classification," maintain that prototypes are one possible approach to classification, provided they are derived from "ideal types." These authors maintain that ideal types, a concept derived from Weber by way of Jaspers, provide a methodological instantiation of the circumstance that the actual nature of mental disorders is unknown. The use of ideal types in psychiatry would involve the creation of classifications on the basis of a consensus among practitioners as to what arrays of symptoms tend to be grouped together. The authors, quoting Weber, state that ideal types are "formed by the one-sided accentuation of one or more points of view...and by the synthesis of a great many diffuse...individual phenomena" (96). Wiggins and Schwartz then state that,

> ...mental disorders can be best defined using ideal types. Because they make no claim to truth, psychiatrists should be able to agree on their merely heuristic value. Because ideal types are more or less arbitrary nominalistic concepts and not fixed naturalistic ones, they can be adapted easily to accord with different research goals. For instance, an ideal type could be changed readily into a prototype or dimension to suit various research purposes...Ideal types ...should not be viewed as an *alternative* to dimensionism, prototypes, or polythetic concepts (96).

As far as I am able to understand this proposal, it is an attempt to foster an attitude of openness in psychiatric classification, while at the same time providing a provisionally stable consensus to allow diagnoses to be made with some uniformity. In this sense, it seems to be an attempt to operationalize the phenomenological method. That is, ideal types as conceived by Jaspers are idealizations that resist both dissolution and reification in that they are viewed as possessing ideality, a mode of being, while at the same time remaining in

principle open-ended and subject to correction through further experience. More specifically, with respect to mental disorders excluding those arising from organic brain diseases and those which might so arise, i.e., schizophrenia and manic-depressive illness, the authors, following Jaspers, maintain that all other disorders must not be conceived as diseases, but only as types. Moreover, Wiggins and Schwartz maintain that this conceptualization would enable psychiatrists to grasp the value-ladenness of all descriptions of mental disorders without at the same time jettisoning the notion that the nominalistic ideal types may at some time be found to be at least quasi naturalistic, i.e., accurate descriptions of what is actually the case. For this reason, these authors fault Kendall, whom they maintain went too far "by implying that all mental disorders are simply *problems* which, by virtue of widely accepted value judgments, fall within the expertise of psychiatrists" (99).

Wiggins and Schwartz' proposal regarding ideal types seems to me to be, as mentioned above, an effort either to operationalize the phenomenological method, or to move psychiatry in the direction of the phenomenological method, of which both are advocates. As such, I find their proposal to be interesting and worth considering. However, their reformist approach runs the danger run by all reformist approaches: it may result in forever postponing the revolution. Or, to take a Hegelian-Marxist-Humanist stance, we must negate the negation: we must, insofar as possible, live the values of the revolution before the revolution occurs; if we do not, we end up with totalitarianism. In a sense, Wiggins and Schwartz are proposing that we do this. There is, however, a problem: how do we prevent reification of "ideal types"? Conceiving ideal types is not quite the same experience as the *discovery* of eidetic structures advocated by Husserl through the use of fantasy variation within the phenomenological bracketing of all ontological commitments. I believe Wiggins and Schwartz would agree that Husserlian phenomenology is the most intensive, and most successful, philosophical effort, *pace* postmodernism, since the Socratic revolution to tackle the existential problem of reification of human life processes. The phenomenological attitude was viewed by Husserl as the only attitude that could and would disempower reificatory tendencies. For Husserl, however, the phenomenological attitude could only be authentically adopted through a deliberate, conscious act, i.e., a commitment to the revolution.

Part III of PPPDC, Values, also contains an excellent exploration of sexism in DSM-III-R, Denise Russell's "Psychiatric Diagnosis and the Interests of Women." I will not recite here the depressing and infuriating litany of attacks on women that Russell exposes in DSM-III-R. The key point is made by Russell when she states that "Numerous psychological studies have pointed out that what in the West is generally regarded as the woman's role happens to coincide with what is regarded as mentally unhealthy" (248), rather than being regarded, Russell states elsewhere in the article, as "normal responses to the experience of victimization" (256).

Russell is not very hopeful that these sexist biases will soon be eliminated from diagnostic classification. Her proposal is that, since "values are very important in the diagnostic process, a fact obscured by the use of medical terminology ... the problems of narrowness of focus will only be addressed adequately when the facade of value neutrality is dropped" (258). This seems to me to be an excellent proposal. Russell is, of course, not advocating that psychiatry break up into different schools based on differing values orientations, although one might argue that *de facto*, in actual clinical practice, this is what exists today. Nor, it seems to me, is Russell advocating ethical relativism. Rather, her hope is that perhaps when researchers, clinicians, and theoreticians overcome their need to deny that values are embedded in their work, they will be moved to a deeper level of self-examination and personal and professional values clarification. Furthermore, in a remark that has far-reaching implications, Russell adds that "At least if it is admitted that values enter into the conceptual foundations, then this could form the basis for a debate about their appropriateness—a debate that should extend beyond the domain of medicine because the values concern the right way to live, and medicine has no particular authority on that question" (253). Yet, we might add, since medicine is guided by the value of health, which, as a value, applies without discrimination to all people equally, medicine bears within it a values orientation that is not compatible with actions that negatively affect anyone's health. As Russell points out, the diagnostic category of Self-Defeating Personality Disorder, which is applied much more often to women than to men, acts "to obscure the extent of the oppression of women within modern culture....attributable to their unequal social position.... [S]o if the aim of psychiatry is to improve mental health it should not be introducing categories that could perpetrate that inequality" (257). Let me add here, in conclusion, that Russell's analysis and her proposal for dealing with prejudice in psychiatric diagnostic classification in no way run counter to the phenomenological perspective.

This homology with phenomenology applies also to K. W. M. Fulford's contribution to the Values part of PPPDC, "Closet Logics: Hidden Conceptual elements in the DSM and ICD Classifications of Mental Disorders." Fulford presents a brilliant analysis of the role of values in psychiatric diagnostic classification. In fact, Russell's article works well as a companion piece to Fulford's powerful analysis, and their conclusions are similar: Russell advocates dropping the illusion of value neutrality to expose the evaluative element in the classifications in order to open up dialogue; Fulford advocates that psychiatry needs to recognize that the evaluative component of diagnostic categories is not an evil to be eliminated, but is instead a positive good which renders psychiatry a humanistic endeavor rather than a mechanistic science. J. Z. Sadler and Y. F. Hulgus put the matter exquisitely well in their "Enriching the Psychosocial Context of a Multiaxial Nosology" (Part IV): "If a nosology is thought to be value neutral, the implied values reflected in the nosology will be unintended, yet the practical and political repercussions may be profound. Special interest groups who do not share the implied values...may then contest the nosology" (278). These writers propose a multitheoretical Axis IV which would " reflect a greater pluralism of values in psychiatric diagnosis, rather than an accidental set of values arising out of a commitment to an atheoretical nosology" (278).

Of the remaining articles, the one by P. J. Caws (mentioned above) is important in that in it Caws attempts to answer the most important question that, as Mishara pointed out, is ignored by DSM-III-R: what is the domain of investigation of the psychological sciences, i.e., what is subjectivity? Caws' article is a trenchant, clear, and concrete phenomenological exploration of the nature of subjectivity and of the relation between the various aspects of subjectivity and mental disorders. Caws first addresses, and rejects, attempts to eliminate subjectivity by invidiously contrasting it with "objectivity;" subjectivity is then deemed to be mere fantasy and thus lacking reality. These attempts have come from positivism, behaviorism, and structuralism; but, Caws emphasizes, "The project of eliminating "the subjective" from objective scientific discourse ....would leave science without scientists..." (194). Caws points out that attempts to eliminate

subjectivity fail because subject and object are necessarily complementary concepts and neither can be eliminated.

Caws goes on to delineate the following characteristics of subjectivity: 1) "the subject is always here and now (i.e., *here* and *now* are defined as where and when the subject is) (195)"; 2) subjective attentions is a *"directedness toward the object"* (195); 3) "the subject is not biological or psychological or social, it is the one for whom the distinctions among these categories make sense"(197). Caws refers to this aspect as the *"situated subjectivity model,"* and states that it is "fully compatible with the biopsychosocial model" of Engel (196); 4) "The subject is not even *mental*...it is the point of view from which a distinction between *mental* and *physical* makes sense" (197) "and is ontologically prior to both" (198). After this exploration of the nature of subjectivity, Caws shows that mental disorders, e.g., autistic disorder, identity disorder, and schizophrenia, can be characterized in terms of the status of the patient's subjectivity vis-a-vis these, and other, aspects of subjectivity.

Caws' primary purpose in his article is to show that "psychiatry is not neurology," and that *"the object of psychiatry is the subject in relation to its objects.* It is perhaps the only medical specialty that has a relational object rather than a physical or systemic one" (206). As far as this reviewer is concerned, what is most significant about Caws presentation is that he shows that it is only within the perspective of philosophical phenomenology that the subject can, with logical and empirical consistency, be viewed as relational rather than as physical. Readers are invited to compare Caws' views with those of Kenneth Schaffner who, in his "Psychiatry and Molecular Biology" makes a forceful attempt to place psychiatry with a modified reductionistic program. Since, as Caws shows, the phenomenological perspective rejects all forms of physicalist reduction of subjectivity, the two articles provide a challenging contrast in perspectives. Finally, another perspective is presented by Alfred Kraus in his article in Part I: "Phenomenological and Criteriological Diagnosis: Different or Complementary." I regard Kraus' position as different from both Mishara and Caws because the former, unlike the latter, views phenomenology from the Heideggerian perspective. Husserl himself rejected Heidegger's views and considered those views to be distortions of his own. The Heideggerian version of phenomenology, if it is to be so designated, is not compatible with that of Husserl, and should not be viewed as if it is so compatible. Heidegger believed that Husserl had not succeeded in transcending positivism, and unlike Husserl, he viewed science as inherently threatening to humanity.

As should by now be evident, PPPDC is a veritable treasure trove of ideas, insights, and challenges to the major tradition in theory of diagnostic classification. Moreover, PPPDC is the most sustained and serious effort yet made to rethink the philosophical foundations of psychiatry. Beyond even this, PPPDC is a testament to the inseparability of philosophy and the sciences of the mind. Here philosophy is viewed not as the positivists viewed it, i.e., as the mere "handmaiden to science;" rather, in PPPDC philosophy is viewed as a full and equal partner in her own right, whose love of wisdom may yet provide the foundation for a new science, one that honors humanity, not in the breech, but as Socratic midwife of the soul.

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Congress to issues of political correctness (cf the *New York Times*, Arts and Leisure, Feb. 11, 1996 on the Freud postponement as well as the bowdlerized Hiroshima exhibit and the canceled exhibit of slave life in the Southern plantations); and as an example of the rather virulent anti-Freudian and anti-psychoanalytic animus that has taken hold in some quarters of our culture. Familiar figures in the camp of Freud debunkers, in addition to Swales, are Adolph Grünbaum, Frederick Crews, and Jeffrey Masson.

I find all this Freud-bashing more than a little puzzling. Aside from the fact that there would be nothing inherently "wrong" in the Library of Congress's mounting an exhibit that offered a favorable and acknowledgedly one-sided portrait of a historical figure, and even granting the detractors' argument that a major purpose of the exhibit was to provide the psychoanalytic establishment an opportunity to buoy up its sinking ship, it is the venom of the attacks of people like Crews that remains mystifying.

On two counts at least I find these anti-Freudian barrages misguided. First, they involve a rather blatant denial of of Freud's (too me) enormous and enduring effect on twentieth century culture. Whatever one thinks of the merits of psychoanalysis as a therapeutic modality, Freud is a fixture of our group mind. In an earlier generation Thomas Mann and Linus Trilling recognized Freud's place in our culture. In our generation the same recognition has been accorded by figures such as Paul Ricoeur and Harold Bloom. Over thirty years ago Maurice Merleau-Ponty suggested that we learn to read Freud the way we read a classic. He meant by this that we would read and take from Freud the way we read and take from Plato. In this sense we are all Freudians in the way we are all Platonists, and it would be as unproductive to dismiss Freud as "wrong" (the title of a recent book, *Why Freud was Wrong*) as it would be to dismiss Plato as "wrong." A similar point was made recently by Thomas Nagel:

> His [Freud's] influence is not like that of a physicist who claims to have discovered a previously unobserved particle by an experiment which others now think to be flawed. Whatever may be the future of psychoanalysis as a distinctive form of therapy, Freud's influence seems to me no more likely to be expunged from modern consciousness than that of Hobbes, for example, or Descartes. Such thinkers have an effect much deeper than can be captured by a set of particular hypotheses, an effect that would not go away even if, in a wave of Europhobia, their writings should cease to be read. [*NY Review of Books*, May 12, 1994]

The difficulty we have in allowing Freud to settle into this status as classic is evident in the opposite reactions of the press toward the exhibit postponement. While *Newsweek's* (Dec. 18, 1995) response was to imagine dismissively that we will think of Freud as "an old joke that everybody gets, but no one can remember how important it once was," the *Times'* (Dec. 10, 1995) reaction to the fracas over the postponement was that "it goes a long way toward showing that despite what Freud's critics say, Freud is far from dead."

The second point entirely missed by the detractors is the degree to which Freudian psychoanalysis continues to in-

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form psychiatric work. Again, one needn't be a card-carrying psychoanalyst to recognize the extent to which we trade on psychoanalytic notions in our daily practice. Only a rigid neurobiologist or a full-blooded behaviorist could deny this influence. (And most behaviorists are *cognitive*-behavioral therapists—thus opening the door to psychodynamic notions.)

I might also cite the elegant empirical research that has been carried out comparing psychotherapy and psychopharmacology in the treatment of depression—and demonstrating the equivalent efficacy of the former. While the psychotherapies in this research are structured short-term modalities, they are clearly informed by concepts carried over from the psychoanalytic tradition. Now the detractors (Swales is a self-taught historian, Crews a professor of literature, Grünbaum a historian of science) could of course declare that we practitioners are simply wrong and should be required to cease and desist. Let us allow that they wouldn't do anything so silly. What they *should* do is recognize the degree to which Freudian notions are interwoven into the very fabric of everyday psychiatric practice.

To return to my earlier question, if there are good reasons for finding these purveyors of anti-Freudian invective wrong-headed in their attitude, how *do* we account for that attitude? Not surprisingly, psychoanalysis has a response to this question—the response it has always had for its critics. You simply interpret their resistance. Peter Gay, an eminent historian, Freud biographer, trained psychoanalyst, and member of the exhibit advisory committee, saw the furor over the exhibit as "evidence, if any more were needed, that 'Freud's message is really hard to take...Society wants people to behave, but the kid in all of us wants everything'" (*NY Times*, Dec. 10, 1995). The quasi-official psychoanalytic response was offered by Jonathan Lear, a philosopher and psychoanalyst, in an article in *The New Republic* (Dec. 25, 1995). After engaging the detractors Lear writes:

> What is at stake in all of these attacks? If this were merely the attack on one historical figure, Freud, or on one professional group, psychoanalysts, the hubbub would have died down long ago...The real object of attack—for which Freud is only a stalking horse—is the very idea of humans having unconscious motivation. A battle may be fought over Freud, but the war is over our culture's image of the human soul. Are we to see humans as having depth—as complex psychological organisms who generate layers of meaning which lie beneath the surface of their own understanding? Or are we to take ourselves as transparent to ourselves?

Now these responses are certainly self-serving, and as just indicated they perpetuate a long and dubious tradition in psychoanalysis of disarming the enemy through interpretation. On the other hand, that the responses are self-serving does not make them wrong. And indeed, in this case they seem to have merit. There is something in the ferocity of the critics' attacks that smacks of the psychology of protesting too much—and that invites interpretation.

While not disagreeing with the psychoanalysts' defense that their detractors are caught up in a denial of the unconscious, I will suggest another dimension of the latter's protest. The explanatory power of psychoanalysis is so great—and seductive—that it almost inexorably swallows up the world in its categories. In its way psychoanalysis is the Hegelianism of the twentieth century. Lear's article is an example of this. Even granting the limitations of psychoanalytic understanding—"The proper attitude for an analyst is one of profound humility in the face of the infinite complexity of another human being."—the relentless force of psychoanalytic understanding leads him to suggest that psychoanalysis preeminently in this century has its ear attuned to the deeper currents of life— "In all the recent attacks on Freud, can't one hear echoes of Oedipus's attack on Tiresias?" He is of course probably right, but it may this demeanor of certainty that so annoys psychoanalysis' critics—and that provoked a stinging rebuke (*The New Republic*, Jan. 29, 1996) from Joyce Carol Oates (along with the predictable knee-jerk rejoinders from Grünbaum and Crews) to Lear's article.

For me the debate over psychoanalysis seems distinctly unproductive. I would propose that we grant Freud his rightful place among the classics of our culture and be done with it.

James Phillips, M.D.

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