AA P&P Association for the Advancement of Philosophy and Psychiatry

Bulletin

Volume 9, Number 1 **2001**

From the Editor

(In my role as editor of this publication–and secondarily as a practicing psychiatrist–I have felt it appropriate to provide a response to the provocative column of my colleague, Christian Perring, in this issue of the Bulletin. In his discussion of the dangerous side effects of the newer antidepressants, Christian does try to leaven his critique with some statement of the other side of the argument. My challenge to him remains, however, that he is not sufficiently critical of the Prozac-bashing literature he cites. Regarding his own question as to why the anti-antidepressant literature has not generated more controversy, I am of course sympathetic to one of the reasons he considers, namely, that the attack on the antidepressants is a non-event that has not generated controversy because there is not much real controversy there.

It does seem appropriate to discuss the Prozac phenomenon in the context of a column on philosophy and psychiatry in the media, since so much of the discussion has taken place in the popular media, and it seems so difficult to move the discussion beyond the media. After we have had enough of the cosmetic pharmacology nonsense of Kramer's book and of the Prozac-bashing of Prozac Backlash and its ilk, there remains a serious discussion to be engaged. (See Jennifer Radden's review of T. M. Luhrmann's book in this issue for an example).

My own point of view as a practicing and prescribing psychiatrist is that the SSRIs and other newer antidepressants are very helpful to a lot of people and that the risk/benefit ratio tilts way in their favor. The questions they raise in clinical practice are usually much more mundane than suggested by the all-good/all-bad controversies–questions such as why one (or none) works so well with one patient and not another, what to do about such real and uncontroversial side effects as weight gain, emotional flattening, and negative sexual effects, and questions about the correct balance of psychopharmacology and psychotherapy with any particular patient. However, even granting my positive attitude toward the agents (an attitude shared, I am confident, by the majority of my colleagues), questions remain that go beyond the office concerns of daily practice and that touch on societal, ethical, and philosophical concerns. These are questions such as whether every degree of dysphoria, cosmetic pharmacology aside, should be treated with antidepressants, questions about their widespread use and our tendency to look for a technological fix for too many of our problems, questions about their promotion by the pharmaceutical industry through popular advertising and the growing influence of the industry on our field and our organizations, and questions about the worldwide incidence of depression and the place of the antidepressants, versus other remedies,

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President's Column

"Postpsychiatry" thinking has drawn considerable attention in Britain since psychiatrists Patrick Bracken and Philip Thomas outlined their "new positive direction for theory and practice in mental health" in the pages of the *British Medical Journal* in March 2001, and it behooves us to examine the philosophical claims supporting those recommendations.

The recommendations promoted by postpsychiatry (also known as 'postmodern psychiatry') are various, and at first glance unrelated: a rejection of (i) "faith in the ability of science and technology to resolve human and social problems"; of (ii) the "medical control of coercive interventions," and of (iii) emphasis on the individual's circumstances and traits in understanding psychiatric disorder. But Bracken and Thomas provide a unifying framework for these particular proposals by reference to the historical roots of modern psychiatry and its characteristics as a product of the European Enlightenment. Each tenet derives from an aspect of the "postmodernist" rejection of Enlightenment concepts, categories and methodology. Thus, with its favoring of reason and rationality, the Enlightenment led not only to the social exclusion of the mad as unreasonable, but to their role as objects of study and treatment using rational scientific method. (At least this is what present day historians, influenced by Foucault, assert.) Similarly, with its emphasis on the individual subject, the Enlightenment invited a de-contextualizing of mental disorder: it was a disorder in the individual, not a product of social, cultural or economic forces.

With this theoretical background, the thematic unity of postpsychiatry becomes clearer. If we reject the Enlightenment focus on the isolated individual with its adherence to methodological individualism, then we lose confidence in any appeal to individual circumstances and traits to explain and understand psychiatric disorder. If we reject the normative dualism which contrasts rationality with irrationality or unreason, we lose faith not only in rational scientific method with its (technological) tools, but also in a perceived underpinning for coercive psychiatry–the scientific authority and moral warrant for imposing treatment against the patient's wishes.

The new agenda for mental health care dictated by postpsychiatry places emphasis on *context* ("social, political and cultural realities should be central to our understanding of madness"); on *group*, rather than individual, responses to disorder (this includes acknowledgement of the social and economic causes of mental disorder as well as networking and self-help, client group approaches to treatment); and an *ethical* orientation (rather than "the idea that science should guide clinical practice"). Recommendations are not fully detailed, but they include: an approach to post-institutional care closer to the community psychiatry model; care which includes peer group support on the model of the Dutch Hearing Voices Network; and more sensitivity to cultural variation and values in treatment. (Bracken and Thomas provide an example in which a Sikh woman was given

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culturally appropriate intervention by a visiting Punjabi-speaking nurse from the local Home Treatment Service).

Much in this agenda is appealing and desirable. But the derivation of such an agenda *from postmodernist theorizing* may be overstated and, despite initial disclaimers from the authors, dangerously open to misinterpretation. That biomedical psychiatry fails the mentally ill in many of the ways adduced by Bracken and Thomas, is undeniable. And that the recommendations of postpsychiatry would both enhance the lives of the mentally ill and add to our understanding of mental disorder also seems true. But are the weaknesses in the present system usefully explicated through the postmodernist critique of the Enlightenment? Perhaps not.

The claims of the postmodernists may or may not be true or even coherent: at any rate, they make flimsy infrastructure. Let us challenge one corner: the Foucaultian historical analysis of the treatment of the insane since the seventeenth century, on which Bracken and Thomas rely. Arguably, the plight of the mentally ill would be significantly worse than it now is were it not for Enlightenment categories and concepts, such as that of human rights. The lives of the mentally ill seem to have been improved by our admittedly halting, and incomplete recognition that by dint of their human dignity (another Enlightenment concept), itself bound up with their intrinsic *capacity* for rational autonomy (and another), the mentally ill deserve humane care and treatment! Similarly, although the coercive nature of (some) psychiatric treatment is here attributed to the Enlightenment, and other people's rights to safety are invoked to justify imposing treatment on the dangerous mentally ill, we must remind ourselves that the *right to refuse treatment*, which has sometimes successfully protected patients against coercive, paternalistic treatment during the last decades of the twentieth century, also derives from the liberal tradition of the Enlightenment.

Even Enlightenment science and technology, arguably, can be credited with instigating some of the progressive proposals in the 'postpsychiatry' agenda. Bracken and Thomas appeal to Muir Gray's characterization of the priorities of today's society to which all health care must be responsive: concern about values as well as evidence; preoccupation with risk as well as benefits, and the rise of the well informed patient. Yet the informed risk evaluations made by the patient in modern day health care settings are possible thanks to information on risks and benefits provided, in part, through science and technology, on the one hand, and an acknowledgement of the patient's (rational) autonomy as a value to be honored, on the other.

Without its critique of Enlightenment ideas as a unifying theoretical foundation, postpsychiatry is perhaps diminished in more than name. (It is still 'post modern' in the looser, but safer, sense of contemporary.) It becomes, again, a laundry list of recommendations for revisions throughout psychiatric practice and mental health policy. But it is no less important for that. Whether or not they can be supported and organized around one theoretical position, this set of recommendations makes a serious contribution toward the goal of rethinking psychiatry for the twenty-first century. As such, they may be placed alongside critiques from many sources: the medical anthropologists who identify social disruption, not genes or brain defects, as the primary source of mental disorder; the self-help, survivors' and consumers' movements which promote non-medical treatments; the civil rights lawyers fighting against paternalistic coercive treatment; and even those within biomedical ethics identifying and emphasizing the values inherent in psychiatric practice.

"Postmodern" or not, postpsychiatry cannot be ignored.

Jennifer Radden, D. Phil.

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The Phenomenological World in Buenos Aires

A report of the 5th International Conference of Phenomenological Psychology and Psychiatry, held in Buenos Aires, from September 20–22, 2000, at the Museo Roca, Buenos Aires.

We owe to Professor María Lucrecia Rovaletti, holder of the Chair in Phenomenological and Existential Psychology at the University of Buenos Aires and Researcher at CONICET, the extraordinary opportunity to participate in the biennial meetings dedicated to phenomenology that began in 1992 and have enjoyed the participation of researchers and academics from various countries such as the USA, Uruguay, Chile, Brasil, Mexico, Columbia, Argentina, France, Italy, and Belgium, among others. Conference themes have revolved around fundamental categories of phenomenological psychology and psychiatry such as corporiality, temporality, and space.

This 5th Conference, sponsored by the Psychiatric and Psychological Act Foundation of Latin America and the Mainetti Foundation for Progress in Medicine, was considered of "national interest" by the Honorable House of Deputies of the Nation, and was dedicated to the theme of "Mind, Language, and World."

This theme, which would seem from a perspective of simple idealistic and realist philosophies to involve an irreconcilable opposition, constitutes the fundamental nucleus of phenomenology. As Merleau-Ponty himself indeed says, "The most important accomplishment of phenemology has, beyond doubt, been to have unified an extreme subjectivism with an extreme objectivism in its notion of world or of rationality" (Preface, *Phenomenology of Perception*). On the other hand, the central place of language in the phenomenological tradition has permitted psychology and psychiatry to advance beyond the narrow limits already indicated. Thus, for example, in the Merleau-Ponty conception of "the body as expression" we encounter one of the fundamental transformations effected by phenomenological thought for the understanding of world, mind, and language.

Before describing some of the presentations from the conference, I would like to emphasize what in my judgment constituted the major virtue of these meetings. Inspired by the enthusiasm and work of Professor Rovaletti, a group of about twenty-five thinkers from various countries overcame the barriers imposed by different languages, cultures, and habits to share over the course of three intense days the world of phenomenology. The papers and discussions, but also the informal conversations, served to constitute a group that transmitted that genuine phenomenological spirit of *opening to the other*. We did phenomenology through the description of experience, through theoretical questioning, and through epistemological debate, and we found ourselves in that world in which psychology and psychiatry encounter and overlap with philosophy. Let me discuss here some of principle themes covered in the the presentations.

Let us begin with the theme, "World" and the experience of mundaneness. Two papers by professors of the University of

Paul Valéry at Montpellier, France, "Recreation of the world and the self in existential psychodrama" by José-Luis Moragués, and "Psychophenomenology of the fabric of the world" by Brigitte Leroy-Viémon, offered a rigorous and innovative phenomenological perspective on therapeutic work with patients at risk.

Professor L. Ricón from the University of Buenos Aires, in "Uncertainties and certainties in practice," posed the questions arising from clinical practice where the one certainty resides in the necessity to use our professional means to relieve human suffering.

In her paper, "Image of self and image of world in the *burnout syndrome*," Professor M. I. Pérez Jáuregui of the University of Salvador, Argentina, analyzed the process of development of this syndrome and its consequences in the projection of a work life. In "World(s) and psychopathology (s): a phenomenological, transcurtural mirror," Professor Virginia Moreira of the University of Santiago, Chile and the University of Fortaleza, Brasil, took up transcultural and phenomenological themes and sought to show the relation of mutual constitution between psychopathology and culture.

Saúl Paciuk of the Uruguayan Psychoanalytic Association, in "To think a world," suggested how thinking provokes an encounter of subject and world, that is to say, with things, with others, and with oneself.

In a presentation entitled "A notion of world as represented in the context of artificial intelligence and in Husserl's empirical phenomenology," Professor G. Vargas Guillén of the National Pedagologic University of Columbia showed how Husserl's descriptions in *Ideas II* constitute a source of empirical hypotheses for research in contemporary cognitive science, especially artificial intelligence.

Drs. C. Dragonetti and F. Tola from CONICET, in a paper on "Mind and world in Dignaga," analyzed the thesis of this Buddhist philosopher from the fifth century that *"only-consciousness" exists*, and his explication of the world as a special form of *cognizable object*.

For his part, Professor Alberto Carillo Canaán of Benemérita University de Puebla, Mexico expounded on the interweavings between "World and language in Heidegger," showing how already in *Being and Time* the question of the meaning of being is supported by a conplex conception of language.

Other works, less phenomenologically oriented, were also delivered. In a paper entitled "Pluralism: about the thought of Nelson Goodman," Professor Samuel. N. Cabanchik of the University of Buenos Aires-CONICET, Argentina demonstrated how for both Putnam and Goodman the unitary world can not consist in the representation of any subject, any theory, or any language, not because it exists as ineffable and beyond human grasp, but rather because it is in the best of cases a metaphor for representing its own impossibility, the impossibility of a totalization of experience. In another paper, "The scientific realism of Rom Harré," Christian Carman from the National University of Quilmes-CONICET, Argentina analyzed Harré's effort to provide a foundation for the sciences, an ambition that had also emerged in the origins of phenomenology. In "Contingency and conceptual change," Daniel Kallpokas from the University of Buenos Aires-CONICET, Argentina, starting from the philosophy of Richard Rorty, analyzed the consequences that follow from the recognition of the contingencies of vocabularies and evaluated the implications of this phenomenon for the question of conceptual change.

Another group of presentations centered around the theme of language. In "The principle of dialogue in psychiatry," Dr. Jean Marc Chavarot from the School of Daseinsanalysis in France, taking off from the phenomenolical principle of susbjectivity as intersubjectivity, postulated that a mental or emotional disturbance is in large measure a disturbance of dialogue. Professor Norberto Conti, University of Buenos Aires, starting from some developments in the epistemology of Thomas Kuhn and from the three paradigms of the history of psychiatry of the psychiatrist, G. Lanteri-Laura, sought to articulate some aspects of the external and internal history of psychiatric discourse.

Professor Lysianne Janssens-Bertelet from IUFM de Lille, France, in "The science of language and phenomenological psychiatry, a problematic relationship," confronted the difficulties in the relationship between the phenomenology anthropology of H. Maldiney and the linguistic theory of G. Guillaume. In my own (Professor Nelson Coelho, Jr., University of Sao Paulo, Brasil) paper, "Merleau-Ponty and language: the subject speaks, but also language," starting from Merleau-Ponty's philosophy of ambiguity in which there is neither primacy of speaking subject or of language itself, I noted that *language speaks*, and as Broekman would have said (4th Conference, 1998), *no longer always clearly*, and citing Merleau-Ponty's "Indirect Language and the Voices of Silence," tried to develop modalities of

AAPP Annual Meeting 2002

Psychiatry and Personal Agency: Nature vs. Nurture Revisited

May 18 & 19, 2002
Philadelphia, PA, USA
(in conjunction with the American Psychiatric Association Annual Meeting)

The association for the Advancement of Philosophy and Psychiatry (AAPP) is requesting abstracts for papers to be presented at the 2002 Annual Meeting, May 18 and 19, 2002, in conjunction with the American Psychiatric Association meeting in Philadelphia, Pennsylvania. Papers on the theme of Psychiatry and Personal Agency may emphasize phenomenological, theoretical, historical or case oriented approaches.

Abstracts must be submitted in triplicate to: Marilyn Nissim-Sabat, Ph.D., Philosophy Department, Lewis University, One Independence Parkway, Romeoville, IL 60446. Submissions must be postmarked by December 15, 2001. Abstracts will be refereed by members of the AAPP Executive Council and their designees, and acceptances will be mailed no later than January 15, 2002. Authors with accepted abstracts will read their papers at the 2002 Annual Meeting. Accepted papers will be presented within a strict 30-minute time limit.

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hearing and speaking that permit transformative possibilities in therapeutic relationships.

Professor Daniel Lesserre from the University of Salvador-CONICET, Argentina, in "Kant and Husserl: meaning from the transcendental perspective," analyzed the "linguistic turn" in twentieth-century philosophy and how the theory of meaning constitutes one of the nuclear theories across the decisive contribution of phenomenological and transcendental reflection. In "The ideality of language and the problem of psychologism," Professor Carlos Buscarini from the Juan XXII Institute, Bahía Blanca, Argentina confronted the conceptual differences of language in the work of Husserl, in his eidetic phase as well as in his constitutive phase.

Professor Antonio Castorina from UBA-CONICET, Argentina, in "Recent polemics in constructivism," showed how epistemological constructivism, despite being centered in the significative action of the subject vis-à-vis the world, and despite a rejection of any form of dualism, nevertheless in the social constructivist version retains the spirit of a "split" in modern philosophy in dissolving the subject of knowledge in the service of discursive practices. The thought of Merleau-Ponty is analyzed as a response

Three other presentations should also be highlighted as involving the field of phenomenological psychopathology. The first, "Prolegomena for an existential analysis of neurosis: the hysterical, phobic, and obsessive styles," by Professor Jeanine J. Chamond of the University of Montpellier, France, considered these neurotic styles as existential styles of *being-in-the-world*, *being-in-time*, and *being-with-others*. In "Body and world in delusional depression," Professor Otto Dörr Zegers from the University of Chile analyzed a case of Cotard's Syndrome, showing that at the base of this nihilistic delusion there is a loss of the capacity for pleasure, as well as also a loss of the capacity to perceive the corporal presence of the other—an inability to construct the experience of one's own body and therefore of the world. Dr. Raúl Balbé from the Center for Philosophical Studies in Argentina, with his paper, "About delusion," presented a dynamic-structural, psychopathological understanding of the delusional world from the perspective of Jansarick's thought.

Finally, I must highlight the presentation of our hostess, M.L. Rovaletti, on "Birth and originary filiation: concerning early relationships in the thought of Husserl," in which she posed the notion of intentionality in Husserl as instinctual sociability. Starting from the Husserlian idea of the person as relationship, she considered the mother-infant bond as an exemplary situation in understanding the connection of self-consciousness and consciousness of the other.

With this brief report, we are well aware that it is not possible to do justice to the boldness of the papers and much less to the discussions that followed. These encounters of phenomenology in Buenos Aires were primarily characterized by the quality and respect that were evidenced in the ample and heated debates in which the participants appeared able to free themselves, as least temporarily, from their personal convictions in allowing themselves to be led by the force of the words of their interlocutors. This space of exchange and promulgation of research in the field of phenomenological psychology and psychiatry constitutes an extraordinary opportunity for dialogue, and thus it remains only to invite you to the next of these conferences, which take place every two years in the sunny, flowering springtime of Buenos Aires, that beautiful capital of Argentina.

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Review

When Self-Consciousness Breaks: Alien Voices and Inserted Thoughts, by G. Lynn Stephens and George Graham. Cambridge, MA: MIT Press, 2000 (198 pages).

Stephens and Graham have written an interesting and useful contribution to the philosophical-psychiatric enterprise in *When Self-Consciousness Breaks, Alien Voices and Inserted Thoughts*. They take as their subject the clinical phenomena of auditory hallucinations and inserted thoughts as they generally occur in schizophrenic patients. These two classes of symptoms undermine the philosophical and common sense assumption that the individual is the author and owner of his or her thoughts. How can I think a thought that I believe was originally thought and later placed in my mind by another person? How can I form language from my own mind and believe it comes from outside me? The subsequent analysis attempts to make sense of these apparent contradictions.

The authors begin with a brief summary of the premises that are challenged by schizophrenic symptomatology. They first invoke William James as spokesperson for the point of view that mental processes are by necessity felt to be our own. They then undertake an analysis of the two major competing theoretical camps about auditory hallucinations: the Self-Produced Misattribution theory (SPM) and the Auditory Hallucination Model (AHM). The former of these is the well-known subvocalization model. That is, the subject is whispering and mistakes this for voices. This point of view is given reasonable attention, but is rejected because of the paucity of supporting evidence and its lack of capacity for explaining the alien attribution of such whispers.

Stephens and Graham use the AHM model as their point of departure for the rest of the book. However, they make several important preliminary points before diving into their analysis. First, any model must help explain the alien attribution of auditory hallucinations, not just their production. The second point, addressed earlier in the book, is that auditory hallucinations may in fact be neither auditory nor hallucinations. The authors review the evidence and conclude that "verbal hallucinations" would be a better name for this phenomenon. Schizophrenics are often aware that their verbal hallucinations (VH) do not have the same perceptual feel as normal external speech. Lastly, they explain that they are endeavoring to describe and examine the experiences of patients in order to say more about normal higher mental function, not to draw broader psychiatric, neurological or therapeutic conclusions.

At this point the clinically trained and philosophically interested reader (like me) is curious to find out what will happen and is also appreciative that the authors have trained their philosophical sights on common important clinical areas (unlike other work that often emphasizes uncommon neuropsychologcial syndromes).

A 1986 paper by the psychiatrist Ralph Hoffman serves as the starting point for the meat of the analysis. Hoffman's theory is briefly that schizophrenics make verbal imagery (words in your head, like reciting a poem to yourself

without speaking). The verbal imagery may be unintended. The unintended nature is secondary to its departure from normal discourse planning (so far all of this happens to everyone). This leads to the understandable but erroneous conclusion that the verbal imagery is not one's own. And lastly, a normal mechanism for reality checking goes awry when the individual understandably misattributes unintended thoughts for some one else's. Thus, emerges the VH.

My brief summary does not do justice to Hoffman or the authors in explaining, analyzing, and criticizing the nuances of Hoffman's theory. Additionally, they give ample floor time to some competing views, most notably Daniel Dennett's. The latter's critique lies in the perspective that intentions are based upon other intentions ad infinitum, and would seem to undermine any basis of a theory in a single intention. Stephens and Graham acknowledge the value of this for cognitive theorists, but point out that all intelligent action does not need to succumb to this infinite regress, and then presumably we can start our analysis in the middle if we want. I'm not sure who wins this round, but it does not seem to distract from the logic of the subsequent steps. Again there are other objections and nuances that are dealt with in this section.

Overall, the authors find Hoffman lacking in the ultimate task of this project, to explain the alien nature of VH. In order to move on without him, the authors shift to a new question, that of how to explain thought insertion. This is a very clever move as it illuminates the complexities of perceptual phenomena and focuses on a specific question: namely, whether or not introspection necessarily involves self-attribution of thought. I do have a small bone to pick here. Stephens and Graham claim that thought insertion is the second most studied positive symptom in schizophrenia (after VH). This is highly unlikely. Delusions are extensively studied and inserted thoughts are not a very common symptom in clinical practice. Nevertheless, the authors move and review some relevant theories that may or may not contribute to their argument (namely, motivational theory, monitoring theory, and externality). It is by sifting out what they find logical, supported and useful that Stephens and Graham come to their conclusions about alien thought. They conclude that conscious thought has two components, the subjective and the agential. Subjectivity refers to the quality of cognition as part of one's own mental history, and agency refers to the cognition being intended toward action or activity. Therefore, if subjectivity breaks away from agency one would lose any sense of ownership of his or her conscious activity, making it potentially external (and logically, alien). If agency breaks down, authorship can be placed in another. In a broader version of this they place the malfunctions in the context of one's sense of circumstances, intentions, and sense of oneself ("what they are like or about").

I am of the strong opinion that conventional psychopathology is a powerful and very neglected tool for the illumination of normative aspects of mental function. Stephens and Graham present us with an excellent example of how it's done. They have limited their original task without rarefying their analysis. Essentially they have gone from psychopathology to an important and interesting distinction about consciousness. Surely their conclusions will stir some debate, but I will comment more on what was left out and may have been helpful. I am respectful (and grateful!) that the authors did not make long digressions, create new distinctions, or come up with a new technical vocabulary. I think this speaks well of their project in general. However, I did find myself, while along the journey, leaning out the window and wondering if we shouldn't stop here or there to look around to get our bearings. I do not think the comments I will be making have refutational merit, but they do bear on the topic.

One point of bearing that should have been noted was some important work in closely related areas. In *The Phenomenology of Perception* Merleau-Ponty writes, "A hallucination is not a judgment or a rash belief, for the same reasons which prevent it from being a sensory content . . . At the level of judgement they [the patients] distinguish hallucination from perception." Merleau-Ponty goes on to make many of same points that underlie the book's arguments. A nod may have been in order. Similarly, in the discussion of "motivational" theories of externalization the authors do not mention the name of a very large and still very relevant body of work, psychodynamics.

Another scenic outlook we breezed by many times was the not always coincidental use of the word intention (coincidental, that is, with philosophical intentionality). The connection of our thoughts to things outside ourselves is an important part of this analysis. That connection does not have to be causal to be intentional in the philosophical sense. The remedy here would move them toward Continental thought by placing one's actions in the context of their circumstances, general intentions, and sense of oneself. Again, the authors may have been very wise to avoid this digression into Continental philosophy. I do wonder if an opportunity was lost here to explore an important dimension of the symptoms in question.

Thirdly, I will continue picking at my clinical phenomenology bone. I think inaccurate use was made of obsessive-compulsive disorder symptoms. At times the mental component of a compulsion was confused with an obsession (an intrusive thought). Even with this clarification I feel the exact place of ego-alien thoughts in the Stephens-Graham scheme of things is not quite clear.

One very important phenomenological aspect of VH and inserted thoughts was left untouched and consequently leaves untouched what I believe to be the essential problem in schizophrenia. That is the thematic nature of VH, inserted thoughts, and other schizophrenic symptoms (paranoia, bizarre mental manipulations etc.). The essential issue is that of associations in schizophrenics. With regard to VH, thought insertion, delusions, thought disorder or negative symptoms, there still is no coherent theory explaining why schizophrenics think what they think and how they do it (neural networks have shown some interesting results but remain in their infancy).

Another interesting clinical observation, which I think works in the author's favor, is the common observation of voices "going back into my head," as reported by pharmacologically treated subjects. Typically the voices lessen in intensity and intrusiveness, go back into the patient's head (but are still not their thoughts) and finally become their thoughts. Is this the reknitting of subjectivity to agency?

Lastly I will mention Hoffman himself. Recently he has turned his attention to a new approach to examining VH, that of the use of repeated transcranial magnetic stimulation (rTMS). As published in *Lancet* in March, 2000, Hoffman and collaborators were able to ameliorate VH by using magnetic stimulation to decrease neuronal activity in the receptive speech association areas. I happen to know Dr. Hoffman, and he informs me that he has "departed" from the theory that VH are aberrant speech production. His theoretical interest now is the possible activation by verbal imagery of pathologically yoked speech perceptual and production circuitry. I cannot comment on how Hoffman feels this new theory impacts the other factors in his previous project. His new findings are exciting and may be therapeutically important. It would be

regrettable though, if the line of thinking pursued in this volume was abandoned.

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Review

The Perspectives of Psychiatry, 2nd Edition, by Paul R. McHugh and Phillip R. Slavney. Baltimore: The Johns Hopkins Press, 1998 (332 pages).

I believe that there are only two contemporary books which have tried to make sense of psychiatry as a field: Leston Havens' *Approaches to the Mind* (Harvard University Press, 1986), and Paul McHugh and Philip Slavney's *Perspectives of Psychiatry* (1st edition 1983 and 1986, 2nd edition 1998). Like Havens, McHugh and Slavney focused on identifying different methods underlying basic conceptual approaches in psychiatry. Unlike Havens, they did not focus on different schools of thought in psychotherapy, and they did not emphasize an historical approach of examining founders and followers among the different schools of thought. Instead, they described four different theoretical perspectives in psychiatry:

1. Disease: What the patient *has*. The goal of treatment in this perspective is cure. This view agrees with Havens' objective/descriptive approach and consists of categorical knowledge: one either has or does not have the disease.

2. Dimension: What the patient *is*. The goal of treatment in this perspective is counseling, and this perspective is similar in parts to Havens' existential approach, where the focus is on the human being who may be suffering the illness, not the disease that underlies the illness. This involves continuous rather than categorical knowledge, since all human beings have certain characteristics, and what is relevant is how much of each characteristic someone has. Unlike diseases which one either possesses or does not possess, the dimensional model applies better to aspects of psychological functioning (such as personality traits), which everyone possesses but which may differ among individuals (who might have more or less of particular traits).

3. Behavior: What the patient *does*. McHugh and Slavney relate treatment to a type of reeducation in which the patient learns new methods of controlling or changing her actions. This is the underlying method behind popular behavioral approaches to treatment of depression and obsessive-compulsive disorder. Havens classified this type of treatment under the objective-descriptive approach, since behavioral treatments subscribe to traditional methods of describing objective signs and symptoms.

Here is a case example, from my own practice, of the behavior perspective. The patient was a large full-bodied middle-aged man; with his cap on his lap, and his legs spaced apart, he looked me firmly in the eyes as he blithely related his family's misfortune. His wife had developed depression and OCD, and so had his son, who, a tortured young man now, came for help. The biological tie was strong and obvious: mother and son lived with the same irrational obsessions and phobias. But there were other stresses; the father had been an alcoholic, and he seemed to blame himself rather than his wife's genes for it all. "Once I sent my son to school with a bruise above his eye," he related, " and the social worker called and said that unless I went to AA and to counseling, they would take my kids away. I decided right then never to drink again, and I never have." He drank, he said, because going to the bar was the only alternative to going home; he avoided the obsessional, depressed household by turning to drink; so he stopped.

4. Life story: What the patient *wants*. The goal of treatment is a kind of rescripting of one's life goals. This perspective is future-oriented and takes an overtly hermeneutic perspective in the sense that objective truth is not the purpose one sets; this is similar to the major difference between the existential approach as described by Havens and all the other approaches (all of which seek to obtain objective accurate knowledge). Just as the existential approach simply seeks to understand things rather than explain them, the life story perspective is focused on understanding one's goals or one's ideals, what might be rather than what definitely will be or what has been.

It should be clear that there is a good deal of overlap between the theoretical structures advanced by Havens and by McHugh and Slavney. However, certain differences in emphasis and in content also stand out. Havens more clearly establishes a historical background to his theory and he links the different methods to different historical schools of psychotherapy. McHugh and Slavney provide a more precise distinction of the cognitive-behavioral perspective in psychiatry, but Havens provides better descriptions of the unique methods of the psychoanalytic and the interpersonal schools of thought. The positions described by these authors can be put to some kind of empirical test. In particular, the distinction made by McHugh and Slavney between the categorical and dimensional forms of knowledge are liable to such empirical testing. They assert, rightly I think, that the different perspectives of these two forms of knowledge apply to different psychiatric conditions, and that this application is not arbitrary but the result of empirical studies of these conditions.

I think that McHugh and Slavney's book ought to be widely commended and read. At one level, I see it as a long meditation on Karl Jaspers. The book takes Jaspers' basic concept of pluralism in psychiatry and spells it out in great detail. McHugh and Slavney provide this service in readable English, using current psychiatric terminology, as opposed to the Teutonic travails of reading Jaspers' *General Psychopathology*. That feature in itself would be enough to commend this book. However, in addition, McHugh and Slavney weave in aspects of psychiatric thinking that trace to Adolf Meyer, Kraepelin, and Freud, thus creating an original contribution.

The first edition caused something of a stir. The second edition is more than twice as long, and has been rewritten in detail, rather than simply revised or updated. I am not sure that much has been gained in the process. Many of the changes in the new edition seem to consist of concrete examples that presumably seemed useful in the teaching of these concepts. Personally, I found the first edition more concise and conceptually focused.

The main problem is not so much with the book as with its reception, or lack thereof. These ideas appear to have made very little impact outside of Baltimore, where McHugh has been chairman, and those locales where some of his pupils have emigrated. Similarly, Havens' work has had little influence outside of Cambridge, where for many years he directed the residency program. Why the limited impact? Is our field congenitally unable to think about what it is that we are doing?

Recently, in anticipation of his retirement from the chair at Johns Hopkins, McHugh was invited to give a plenary lecture at the annual meeting of the American Psychiatric Association. In

that lecture, he tried to emphasize the future need for psychiatry to move to a structure or model like the Perspectives. He also focused on the weaknesses of the current approaches, especially the biopsychosocial model and the limited validity of DSM-IV nosology. Yet, while he seemed to strike a chord among the rank-and-file, it seems unlikely that he will influence either the political leadership of the field, or leading researchers (most of whom are purposefully oblivious about "speculative" matters). I am not certain why this is the case, and we in AAPP are obviously trying to change this state of affairs, but, until it is changed, one wonders what exactly will happen.

Will modern psychiatry give up the comforts of biopsychosocial eclecticism? Will neurobiology and genetics make much of this discussion moot? Will the humane approach to each unique individual remain an integral part of psychiatric training and practice? Great ideas require a receptive public. So far, the ideas have been great, but the psychiatric public has been otherwise occupied.

N. Nassir Ghaemi, M.D.

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The Neurohermeneutic Forum

Mental Hygiene in the Year of Our Ford

When Henry Ford conceived his first vast assembly line, he could hardly have envisioned its misapplication to the care of the mentally ill. Yet today's psychiatric paradigms of "cost-effectiveness" do just that.

My own traditional psychiatric training emphasized interviews with a patient as the route to a meaningful narrative whole integrating that person's unique life history. Yet, over the decades since I finished my residency, mandates by HMOs, PPOs, JCAHO, and HCFA have almost entirely reorganized care around problem-oriented treatment plans. These schemes are supposed to distribute labor cost-effectively among specialized clinical team members according to each professional's own disciplinary expertise. It is reasoned that, if psychiatrists limit themselves to biobehavioral issues and leave social workers to concentrate on the psychosocial realms that they know best, more bang for the buck will result.

In striving toward such efficiency, treatment plans have actually splintered psychiatric practice by chopping its principle subject, the whole patient, into discrete "problems" no longer bound together by any meaningful narrative gestalt. The dehumanized result is a Ford-style factory approach in which social workers, nurses, occupational therapists, dieticians, and psychiatrists each perform specialized piecework not for patients but instead to produce restricted, commodified "outcomes."

One suspects that this kind of mechanized division of labor must become self-defeating in the end. Symptoms are treated with quick fixes, and the entrance to the psychiatric ward becomes a revolving door through which the patient keeps returning for repeated hospitalizations. No skilled listener ever assimilates the overall case history, and thus there emerges the ultimate medical error: a human soul is lost in the shuffle.

Treatment plan advocates offer a seductive rejoinder: the behavioristic bent of scientific treatment planning forces clinicians to gauge the progress of patients toward concrete, measurable therapeutic "goals" like the elimination of observably aggressive behaviors. Thus, it is argued, built in feedback automatically monitors whether treatment plans are doing their job.

A critic might reply with questions about the meaning of the word "measurable." Physics, the quantitative empircal science par excellence, has always approached measurement through the mathematical medium of finite real numbers and their countable subsets. When researchers have confronted new phenomena requiring an infinite iteration of procedures in order to organize observational data, they have traditionally paused to revamp their theories. Physicists working at the frontiers of their field have moved on successfully into new domains of insight only after they have found fresh computational methods to make emerging infinite regressions tractable, so that mathematical "convergence" of the infinitely iterated series approximates finite numerical results. Indeed, Planck's solution of the black body problem, Prigogine's contributions to nonlinear dynamics, and current explorations in string theory have all grown from problems in rendering infinite series accessible to finite approximation.

The human mind's intentionality leads to infinitely regressive existential paradoxes. Humans, not computers, grapple with notions of personal mortality implicit in the paradoxical statement, "I do not exist." People cope with such troublesome concepts not computationally but through leaps of faith, madness, and a Byzantine, infinitely regressive wilderness of defenses.

No scientist has yet come up with a new mathematical approach "renormalizing" infinite existential regressions into finite, measurable terms. Unless that can happens, forced empirical straightjackets in treatment planning will not work. Instead of providing reliable feedback about outcomes, quantitatively "monitored" treatment plans as we now know them will only continue to spin off paradoxical therapeutic failures through ever more circular forms of the revolving hospital door.

Donald Mender, M.D.

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Philosophy and Psychiatry in the Media

Reading *Prozac Backlash* (Simon & Schuster, 2000) by Joseph Glenmullen, a clinical instructor in psychiatry at Harvard Medical School, I was shocked to learn that the court decision in the famous Kentucky 1994 trial on the dangerousness of Prozac had in fact been ruled in 1997 as settled out of court, due to a secret deal between Eli Lilly and the plaintiffs. So Prozac was not in fact determined by the trial to be safe, as if often believed. Lilly has used similar strategies in other trials and even in their dealings with the FDA, and Glenmullen's well-documented account of the way Lilly works should give readers pause for thought.

Another major pharmaceutical company recently had a setback. On June 6, 2001, GlaxoSmithKline was ordered by a Wyoming jury to pay millions of dollars in compensation to the family of a man who killed his wife, daughter and daughter, as well as himself, when taking Paxil (paroxetine, called Seroxat in Britain). The jury attributed 80 percent of the blame for the man's behavior to the influence of the medication.

Eli Lilly was also in the news this year in connection with the decision by the Centre for Addiction and Mental Health at the University of Toronto not to hire the prominent researcher David Healy, who is currently at the University of Wales College of Medicine. Healy is author of *The Antidepressant Era* (Harvard University Press, 1998) and he

without speaking). The verbal imagery may be unintended. The unintended nature is secondary to its departure from normal discourse planning (so far all of this happens to everyone). This leads to the understandable but erroneous conclusion that the verbal imagery is not one's own. And lastly, a normal mechanism for reality checking goes awry when the individual understandably misattributes unintended thoughts for some one else's. Thus, emerges the VH.

My brief summary does not do justice to Hoffman or the authors in explaining, analyzing, and criticizing the nuances of Hoffman's theory. Additionally, they give ample floor time to some competing views, most notably Daniel Dennett's. The latter's critique lies in the perspective that intentions are based upon other intentions ad infinitum, and would seem to undermine any basis of a theory in a single intention. Stephens and Graham acknowledge the value of this for cognitive theorists, but point out that all intelligent action does not need to succumb to this infinite regress, and then presumably we can start our analysis in the middle if we want. I'm not sure who wins this round, but it does not seem to distract from the logic of the subsequent steps. Again there are other objections and nuances that are dealt with in this section.

Overall, the authors find Hoffman lacking in the ultimate task of this project, to explain the alien nature of VH. In order to move on without him, the authors shift to a new question, that of how to explain thought insertion. This is a very clever move as it illuminates the complexities of perceptual phenomena and focuses on a specific question: namely, whether or not introspection necessarily involves self-attribution of thought. I do have a small bone to pick here. Stephens and Graham claim that thought insertion is the second most studied positive symptom in schizophrenia (after VH). This is highly unlikely. Delusions are extensively studied and inserted thoughts are not a very common symptom in clinical practice. Nevertheless, the authors move and review some relevant theories that may or may not contribute to their argument (namely, motivational theory, monitoring theory, and externality). It is by sifting out what they find logical, supported and useful that Stephens and Graham come to their conclusions about alien thought. They conclude that conscious thought has two components, the subjective and the agential. Subjectivity refers to the quality of cognition as part of one's own mental history, and agency refers to the cognition being intended toward action or activity. Therefore, if subjectivity breaks away from agency one would lose any sense of ownership of his or her conscious activity, making it potentially external (and logically, alien). If agency breaks down, authorship can be placed in another. In a broader version of this they place the malfunctions in the context of one's sense of circumstances, intentions, and sense of oneself ("what they are like or about").

I am of the strong opinion that conventional psychopathology is a powerful and very neglected tool for the illumination of normative aspects of mental function. Stephens and Graham present us with an excellent example of how it's done. They have limited their original task without rarefying their analysis. Essentially they have gone from psychopathology to an important and interesting distinction about consciousness. Surely their conclusions will stir some debate, but I will comment more on what was left out and may have been helpful. I am respectful (and grateful!) that the authors did not make long digressions, create new distinctions, or come up with a new technical vocabulary. I think this speaks well of their project in general. However, I did find myself, while along the journey, leaning out the window and wondering if we shouldn't stop here or there to look around to get our bearings. I do not think the comments I will be making have refutational merit, but they do bear on the topic.

One point of bearing that should have been noted was some important work in closely related areas. In *The Phenomenology of Perception* Merleau-Ponty writes, "A hallucination is not a judgment or a rash belief, for the same reasons which prevent it from being a sensory content . . . At the level of judgement they [the patients] distinguish hallucination from perception." Merleau-Ponty goes on to make many of same points that underlie the book's arguments. A nod may have been in order. Similarly, in the discussion of "motivational" theories of externalization the authors do not mention the name of a very large and still very relevant body of work, psychodynamics.

Another scenic outlook we breezed by many times was the not always coincidental use of the word intention (coincidental, that is, with philosophical intentionality). The connection of our thoughts to things outside ourselves is an important part of this analysis. That connection does not have to be causal to be intentional in the philosophical sense. The remedy here would move them toward Continental thought by placing one's actions in the context of their circumstances, general intentions, and sense of oneself. Again, the authors may have been very wise to avoid this digression into Continental philosophy. I do wonder if an opportunity was lost here to explore an important dimension of the symptoms in question.

Thirdly, I will continue picking at my clinical phenomenology bone. I think inaccurate use was made of obsessive-compulsive disorder symptoms. At times the mental component of a compulsion was confused with an obsession (an intrusive thought). Even with this clarification I feel the exact place of ego-alien thoughts in the Stephens-Graham scheme of things is not quite clear.

One very important phenomenological aspect of VH and inserted thoughts was left untouched and consequently leaves untouched what I believe to be the essential problem in schizophrenia. That is the thematic nature of VH, inserted thoughts, and other schizophrenic symptoms (paranoia, bizarre mental manipulations etc.). The essential issue is that of associations in schizophrenics. With regard to VH, thought insertion, delusions, thought disorder or negative symptoms, there still is no coherent theory explaining why schizophrenics think what they think and how they do it (neural networks have shown some interesting results but remain in their infancy).

Another interesting clinical observation, which I think works in the author's favor, is the common observation of voices "going back into my head," as reported by pharmacologically treated subjects. Typically the voices lessen in intensity and intrusiveness, go back into the patient's head (but are still not their thoughts) and finally become their thoughts. Is this the reknitting of subjectivity to agency?

Lastly I will mention Hoffman himself. Recently he has turned his attention to a new approach to examining VH, that of the use of repeated transcranial magnetic stimulation (rTMS). As published in *Lancet* in March, 2000, Hoffman and collaborators were able to ameliorate VH by using magnetic stimulation to decrease neuronal activity in the receptive speech association areas. I happen to know Dr. Hoffman, and he informs me that he has "departed" from the theory that VH are aberrant speech production. His theoretical interest now is the possible activation by verbal imagery of pathologically yoked speech perceptual and production circuitry. I cannot comment on how Hoffman feels this new theory impacts the other factors in his previous project. His new findings are exciting and may be therapeutically important. It would be

monly adopted in outpatient settings (and by women clinicians), emphasizing "the way the patient has learned to be with people" offers an equally valid, equally vital approach.

Luhrmann does not come unencumbered to her task, despite this even handed treatment. First, she brings the anthropologist's reliance on the explanatory category of culture. What was "not necessarily intentionally taught" determines the professional culture of psychiatry as much as, or even more than, explicit ideology and rational choice, or, indeed, the doctor's personality. Her psychiatrists are the products of cultural forces beyond their control and understanding and of the roles they are required to play. As she says, "I could see that what they had learned was inherent in the tasks themselves, not due to the style or personality of the doctor"(page 22). Conceptual commitments affect praxis with powerful effects in psychiatry, however, and this image of the psychiatrist as a hapless victim of his or her culture seems slightly too forgiving. At least to some extent, psychiatrists are surely responsible for the model of psychiatry they embrace, and precisely because the concepts, methods and ideas in psychiatry are eclectic and controversial, psychiatrists should be encouraged to recognize this commitment as a personal responsibility.

Luhrmann also brings the medical anthropologist's emphasis on the distinction between disease and illness, which is wielded with considerable effect as she dissects the differences between the two kinds of psychiatry. 'Disease' refers to an abnormality in the structure and function of bodily organs and systems; 'illness,' by contrast, refers to the patient's experience. Thus, the same disease can underlie different illness experiences, depending on the cultural, historical, and individual context involved. This distinction requires Luhrmann to throw doubt on one of the central presuppositions of the biomedical model, concluding that: "You cannot know whether there is really an underlying "disease" in psychiatric illness" (page 20).

Finally, as an anthropologist, Luhrmann introduces the cognitive psychologist's category of prototype reasoning, which she identifies as the process by which young psychiatrists learn to diagnose. Rather than identifying a phenomenon by asking whether it meets specified rules or criteria of membership in some class, prototype reasoning compares the new example to the prototypical or 'ideal' type of that class. We commonly reason by prototype in everyday life and it is an efficient way to name and frame our experience. But the use of prototype reasoning in diagnosis, she points out, is problematic. By ignoring what doesn't fit the prototype, diagnosers are able to treat psychiatric disorders as 'natural kinds,' and to lose sight of the socially constructed aspect of diagnostic classification and categories. They can find a support more apparent than real for their view that psychiatric illnesses are organic diseases, discrete entities or "things," underlying and giving rise to the symptoms experienced by their sufferers.

Luhrmann's criticisms of the biomedical model are far-reaching and unsettling, as these examples illustrate. Whether justifiably or not, she is careful to distance herself from 'anti-psychiatry,' nonetheless. Madness, she insists, is real; and psychotherapeutic alternatives to biomedical psychiatry have their own weaknesses. Luhrmann's work will avoid dismissal as just another anti-psychiatry tract due to its sympathetic and scholarly tone, and the careful, qualitative research on which it is based. Still, broadly 'anti-psychiatry' conclusions are expressed in this book.

After an exhaustive review of the effect of managed care on psychiatric practice, Luhrmann documents what informal observers of the uneasy balance between biomedical and psychotherapeutic emphases in psychiatry have suspected for some time: the tipping point has been reached, the biomedical model is now in the ascendancy, and the tipping agent was managed care. A mix of socio-economic forces and ideology is succeeding in "driving psychotherapy out of psychiatry," despite the acknowledged fact that a combination of psychopharmacology and psychotherapy provides the most effective, and even, in the long run, the most cost effective, therapy. And this is a significant loss, not least for the therapists trained to value psychotherapeutic categories, assumptions and effects.

Luhrmann emphasizes some of the deep contradictions inherent in the biomedical model whose ascendancy seems assured. For example, a person remains, as she says, the best reporter on his or her own psychic state. This is problematic when psychiatry is practiced in such a way that the patient's words matter less and less and these psychic states are too often disregarded in the rush to treat biomedically. A second example: despite the adoption of the market society model of psychiatric treatment in which the client has become a reasonable consumer of mental health services, the contradiction between 'patient-as-adult,' and 'patient-as-child' in need of care and incapable rational decision making gives rise to daily ethical dilemmas in mental health care settings. Finally, Luhrmann considers the meaning of the world-wide epidemic of depression recorded today. Challenging the assumption that depression's major cause is "unrelated personal complaints," she insists with medical anthropologist Arthur Kleinman that we must understand these world-wide symptoms of depression as part of "social suffering." "A recent survey on world mental health observed that in all different age, gender, and cultural categories everywhere, the most important risk factor for mental health is social disruption" - an important point if you are tempted to think of psychiatric illness as purely hereditary, she adds.

In a complex and loosely reasoned final chapter, Luhrmann addresses a moral dimension which, in her words, transcends managed care and ideological tensions. It concerns the attitudes around personal responsibility, agency and personhood which, among other things, she sees as varying according to the two different models. The psychotherapeutic model with its emphasis on intention and 'meaningful connections' preserves the attribution of personhood but risks the cruel and stigmatizing ascription of blame; the biomedical model avoids stigmatizing attitudes but risks dehumanizing the sufferer of mental disorder, particularly when that disorder is chronic and part of the person's identity. Stressing the importance of empathy and compassion to our understanding of these contrasts, Luhrmann frames the kind of dilemma this raises as one of how, confronted with mental disorder, we can "feel compassion for self-destructive intention." The moral psychology here is suggestive but vaguely and insufficiently developed. (It would take another book, a book one hopes Luhrmann may some day write.)

Other critics have documented the growing schism between the two discourses of psychiatry as it affects patients, and have noted the high professional and personal costs of managed care's cost-benefit approach for its consumers. But Luhrmann's effort to disclose the culture of psychiatry allows her to document the unease generated by these trends among practitioners, which others have ignored. In this respect in particular, Luhrmann's is a humane and a powerfully original contribution to writing about modern day psychiatry.

Jennifer Radden, D. Phil.

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Call for Papers

Bioethics announces a special issue on Psychiatric Ethics in 2002. Psychiatric ethics combines the sharpest 'coal face' challenges of clinical practice with some of the deepest problems of general philosophy. Everyone concerned with mental health, whether as a user or provider of services, struggles daily with non-consensual treatment, stigmatization, disputed concepts of disorder, conflicting treatment paradigms (drugs versus psychotherapy), dual responsibility, mad/bad determinations (in forensic psychiatry), and end-of-life issues (rational suicide, psychiatric euthanasia). Yet these practical problems turn directly on such metaphysical conundra as responsibility and determinism, rational choice, reasons and causes, freedom of the will, knowledge of other minds, the nature of the unconscious, liberalism and paternalism, personal identity, the fact/value dichotomy, definitions of knowledge and true belief, cultural constructionism and, given a new urgency by advances in genetics and brain imaging, the mind-body problem.

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The guest editors for the issue are Bill (KWM) Fulford, Professor of Philosophy and Mental Health, University of Warwick, and Honorary Consultant Psychiatrists, University of Oxford, UK, and Jennifer Radden, Professor of Philosophy, University of Massachusetts, Boston, USA. We welcome early discussion of brief proposals/abstracts (maximum 250 words) by email to: k.w.m.fulford@warwick.ac.uk and jennifer.radden@umb.edu.

Jennifer Radden, D.Phil.

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*(**Editor,** Continued from page 1)*

in confronting that massive phenomenon.

These are questions for another day; the immediate issue is that of responding to Christian Perring's column. Because I am neither mainly a psychopharmacologist nor an expert in that literature, I have invited my colleague, Mark Rego, who is both, to offer a 'guest editorial' response to Christian Perring's column. Should he choose, Christian will certainly have the opportunity in future issues to continue the discussion. What follows is Dr. Rego's response. JP)

In this edition of the AAPP Bulletin Christian Perring presents evidence in his "Philosophy and Psychiatry in the Media" column supporting the idea that the SSRI antidepressants are more dangerous than is generally appreciated. Specifically, they are charged with causing suicidality and violence (even murder). Although "balanced" in the sense of presenting two perspectives on a controversy, Professor Perring presents a greatly skewed view of the scientific literature as well as a few mistaken points on the scientific process. Perring's two main sources of information are recent personal injury jury trials and books written with the clear purpose of criticizing the SSRI's (rather than to review the scientific literature).

To begin with the issue of scientific process, Professor Perring states: "Prozac was not in fact determined by the [jury] trial to be safe, as is often believed." The result of a personal injury trial, let alone a settlement as in this case, is not evidence of causality. Even though further legal case study is provided, it does not further the argument.

My second point along this line is in reference to the following comment: "...contrary to the claims of pharmaceutical companies, taking antidepressants may be habit forming and even addictive." It is true that some of the SSRI's have a discontinuation syndrome (Paxil and Effexor are the most common causes of this). Many drugs have such effects (e.g., antihypertensives and steroids), but are in no way addictive. There is a tolerance to adverse and some therapeutic effects that is lost when the drugs are discontinued, thus producing usually mild but occasionally troubling symptoms. Addiction implies craving, increased dosage needs to produce the same effect, and eventually abuse. Increased dosing is often required with antidepressants, but at unpredictable and often long intervals. None of this is the picture of addiction. I have told many of my patients that if antidepressants were addictive, then you could buy them on the street. So far all is quiet on this front of the drug war.

More to the point of this debate is the evidence regarding the psychiatric danger of antidepressants. Since the initial report from Harvard of emergent suicidality in approximately a third of a very small sample (my recollection tells me it was about 40 patients in the total case series) there have been many attempts to clarify this important matter. These include, but are not limited to, post-marketing surveillance as required by the FDA, large cohort studies (including at times upward of one thousand patients, conducted by both drug companies and independent university groups) and very large retrospective meta-analyses of multiple, multicenter studies of the therapeutic effects of SSRI's (in order to pool the data on adverse outcomes). All of these efforts have come out strongly in favor of the safety of SSRI's. If this were not the case, the evidence for dangerousness would have been missed by the FDA, the European Drug Agency, the American and international medical communities and–in all due modesty–me (a point well made by Perring, with the exception of the part about me). I have been a practicing psychopharmacologist for 13 years and after many hundreds of treatments and avid monitoring of the literature, I find SSRI's to be very safe for general use. In fact epidemiological studies of clinical populations to determine risk factors for suicide have consistently found antidepressant use to be a negative risk factor.

In the interest of some "balance" of my own I do have some critical comments about the use of SSRI's. The ease of use (i.e., limited medically significant

adverse effects) has produced not so much an overprescribing, as an incomplete prescribing of these drugs. For example, it has been known for decades that all antidepressants are activating, in the sense that they will potentially exacerbate severe anxiety, mania, and psychosis. I have commonly observed these drugs prescribed by primary care physicians and sadly, psychiatrists, without adequate screening, patient education, and follow-up monitoring for these syndromes. Most if not all of the problems I have observed in practice or read about in the media have arisen from this phenomenon. This can be traced to an over-reliance on pharmaceutical marketing as a source of clinical information as well as pharmaceutical support for independent clinical investigation.

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