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From the Editor

Much of the this issue of the Bulletin is devoted to a provocative article by Patrick Bracken and Philip Thomas, "Postpsychiatry: A New Direction for Mental Health," published last year in the *British Medical Journal*. The article generated an active discussion in the *Journal* (all available on-line); and the commentaries published here, together with the authors' response, continue that discussion and make for a lively and productive debate.

As a reader of the commentaries and response, I am left with many thoughts; but confined by limitations of space, I will limit myself to the expression of one. Inasmuch as the article, with its critique of 'modernist' psychiatry and the latter's putative derivation from the Enlightenment, is so driven by the thought of Michel Foucault, I was surprised that there was no mention in the commentaries of the Enlightenment's great defender, Jürgen Habermas. In his commentary Melvin Woody questions whether the 'postmodern' correctives suggested by the authors are already present in Jaspers, who is portrayed by Bracken and Thomas as typical of modernist psychiatry. But Habermas would take Woody's argument one step further and question whether the Enlightenment itself offered correctives, a "counterdiscourse," to the very problems it was posing. Arguing directly in response to Foucault, he writes:

> Hence it would be a good idea to return once again to the unmasking of the human sciences through the critique of reason, but this time in full awareness of a fact that the successors of Nietzsche stubbornly ignore. They do no see that the philosophical counterdiscourse which, from the start, accompanied the philosophical discourse of modernity initiated by Kant already drew up a counterreckoning for subjectivity as the principle of modernity. The basic conceptual aporias of the philosophy of consciousness, so acutely diagnosed by Foucault in the final chapter of *The Order of Things*, were already analyzed by Schiller, Fichte, Schelling, and Hegel in a similar fashion. To be sure, the solutions they offer are quite different. But if, now, the theory of power also fails to provide a way out of this problematic situation, it behooves us to retrace the path of the philosophical discourse of modernity back to its starting point–in order to examine once again the directions once suggested at the chief crossroads" (*The Philosophical Discourse of Modernity*, MIT, p. 295).

With no space to develop this line of thought further, I suggest only that the discussion is far from complete.

James Phillips, M.D.

President's Column

As I write this column nine months later, people in the US and in other nations around the world are still distressed, grieving, confused and uneasy over the events of September 11th and their sequelae. These personal and national responses are and should be uppermost as we take stock of the new frames of mind and states of heart we discover in ourselves. But it may also be time to reflect on the effects felt within psychiatry and philosophy and the likely challenges to our own particular research field wrought by the train of events begun that day. An obvious question is whether those made especially vulnerable by mental disorder will suffer more than otherwise after such terror? At a meeting soon after September 11th two reports were proffered. Severely ill hospitalized patients (in New York) were described as indifferent and unconcerned, even expressing ignorance of the presence of the World Trade Center towers.The personal terrors of this group, one must presume, were more real, more pressing and more terrifying than any new, external threat. At the same time, a depression sufferer described his own and others' worsening, relapse, and suicidal thoughts in response to those events.

Reading Philippe Pinel on the psychic aftermath of the French Revolution, we are reminded that melancholics were always bellweathers. The causes of Pinel's patients' disorders were many and various, but not least were the "storms of the Revolution," which "stirred up corresponding tempests in the passions of men, and overwhelmed not a few in a total ruin of their distinguished birthright as rational beings." And it was frequently the melancholics who succumbed in this way, ancestors of today's sensitive and alert depressives; the steward of a gentleman of fortune who lost his property by the Revolution and who "overwhelmed by apprehensions for his life, which he perpetually harbored, and which the violence of the times were too much calculated to excite...at length became insane;" another man who, "deprived by requisition [for the Revolution] of an only son for whom he entertained a most tender affection, yielded to a grief so poignant that it terminated in insanity," and one who, expressing dissatisfaction with the government in the second year of the republic was threatened with the guillotine, after which "he lost his sleep, was exceedingly perplexed," and was confined at the Asylum of Bicetre where "the idea of his ignominious death perpetually haunted him, and he daily solicited the execution of the decree which he fancied to have been passed against him...his mind thoroughly unhinged and deranged." Pinel's eclectic, atheoretical approach, and the powerful and pervasive framing effect of the Revolution, permitted him to locate Paris's terror at the heart of a causal narrative. Perhaps, as the events of September 11th find their place in our cultural story, they will prove to be similarly explanatory.

Both philosophers who have focused their attention on psychiatry and clinicians themselves might usefully contribute to the understanding of this new era. For psychiatry has long concerned itself with attitudes and accompanying norms which seem to have

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undergone the greatest transformation since September eleventh - those captured between the poles of trust and mistrust. All around us we hear the same refrain: we have lost our uncaring confidence in ordinary life; we cannot assume, cannot trust. We no longer take for granted the safety of day to day living, of the planes we board, the air we breathe, the food we eat, the mail we used to open so carelessiy.

Judging appropriate degrees of trust and mistrust is part of clinical knowledge - when too much scrupulosity becomes a symptom; when a persistent doubting of another's intentions and attentions suggests paranoia; when an apprehension of impending disaster is pathological and a sign of illness. The degree of trust and mistrust which it is appropriate and judicious to entertain guides psychiatric diagnosis Moreover, it is also a deeply philosophical question, a question about values, and rationality. We must call upon concepts which are the stock in trade of clinical judgement and are also deeply philosophical as we attempt to evaluate the character of the enemy - of Bin Laden's anti-American rhetoric, or the suicide bombers' religious zeal. When, even in the dizzyingly unverifiable atmosphere of religious and metaphysical beliefs, do ideas count as delusional ? If the cause is perceived to be right, is a zealot's suicide rational, rather than a sign of depressive pathology ? The prominence into which these norms about trust and rationality have recently been thrust indicates the direction of new research. For better or worse, we inhabit a different culture in this world of 2002. It is one which requires more than a merely intuitive understanding of these norms and ideals, and one to which careful, collaborative work by philosophers and clinician can contribute immeasurably.

On a more personal note, other duties have required me to step down from the position of AAPP President. I hand the reigns to my Vice-President Dr Jerome Kroll who will guide the organization with insight and imagination. Jerry Kroll was a founding member of AAPP, he is a distinguished scholar as well as a practitioner and teacher, and I know as the result of his quietly effective leadership, AAPP will flourish and grow during his watch.

Since this column represents my last in the Bulletin, let me finish by conveying the optimism I feel about the research field which has emerged at the intersection of the two disciplines of philosophy and psychiatry. Lively local groups across the US; an increasingly known and widely respected scholarly journal (*Philosophy, Psychiatry & Psychology*); regular, stimulating conferences and panels; the presence of international links, conferences, groups and associations spanning not only Europe but Asia, Australasia, South America and Africa; a large number of recent books and two specialized series with distinguished university presses (MIT Press's Philosophical Psychopathology series edited by Flanagan and Graham, and Oxford University Press's new International Perspectives on the Philosophy of Psychiatry series edited by Fulford, Sadler, Stanghellini and Morris); graduate programs with a focus on philosophy and mental health, and more research in mainstream philosophy focused on mental health issues - these are some of the signs of a research field which has come of age. AAPP has played no small part in this achievement, and in that we can and should take pride.

Jennifer Radden, D. Phil.

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Philosophy and Psychiatry in the Media

The Court of Public Opinion on The Pharmaceutical Industry

I am glad to have generated some discussion on the role of pharmaceutical companies in psychiatric practice and modern culture in my previous "Philosophy and Psychiatry in the Media" column, and I feel that I should respond to the comments of James Phillips and Mark Rego in that issue on my column.

Phillips suggests that I was not sufficiently critical of the "Prozac-bashing" literature that I site, and Rego says I presented a "greatly skewed view of the scientific literature as well as a few mistaken points on the scientific process." Naturally, I demur from these opinions, and I will give my reasons below. But I also want to take the opportunity to make a larger point.

It is important to be clear about what I was attempting to examine in my column. I was certainly not attempting to address directly in my short column whether the new antidepressants are potentially addictive, whether they can increase the risk of suicide or violent behavior in some people, or even whether the pharmaceutical manufacturers have an undue influence on academic decisions in psychiatry. All these issues were certainly mentioned and would need to be addressed in a complete examination of the role of psychotropic drugs in modern life. But my point was narrower, and I think that both Phillips and Rego missed it, maybe because I did not explain my assumptions fully.

My focus in my column was on what I might call "the court of public opinion." My main point was that it is striking and even surprising that the public remains basically uncritical of the widespread use of antidepressants, despite some court cases and episodes which could be seen as extremely troubling, and that could damage the reputation of Prozac and other antidepressants. I speculated what might explain the public's lack of response to recent developments concerning antidepressants in public life, and I suggested at the very end of my piece that the tide might turn against the pharmaceutical companies if they receive more bad press.

A major assumption in my piece, that I made no effort to spell out, was that the forming of public opinion is not a process of calm and careful deliberation. It strikes me that the number of studies that show the safety of psychotropic drugs and the flaws in the arguments of the "Prozac-bashing" literature have little relevance to how public opinion is often formed.

I can explain my claim by referring to a number of well-known cases.

- In 1975, the Oscar-winning movie *One Flew Over the Cukoo's Nest* showed the use of electroshock treatment in an extremely bad light, and many politicians and activists argued, sometimes successfully, that the treatment should be banned. Yet the evidence for the safety and usefulness of electroshock treatment for severe depression is solid and virtually unquestioned within mainstream psychiatry.
- The amino acid L-tryptophan caused the deaths at least 23 people in 1989, and it subsequently lost its FDA approval. Yet it was used for years previously to 1989 in ways that were apparently beneficial to large numbers of patients.
- In the 1980s, the public began to take note of news stories that anti-anxiety agents such as Valium might be addicting, and the prescription of

Valium and other similar drugs declined massively. But Valium and other anti-anxiety drugs have not been declared unsafe, and they continue to be prescribed.

- In the 1990s, the "anti-obesity" drug Fen-Phen was reported to have caused the deaths of some patients, and it was withdrawn from the market in 1997. Yet some physicians believe that when used appropriately, this medication is safe, and it should not have been withdrawn.
- Also in the 1990s, high profile lawsuits were brought against Dow Corning alleging the danger of silicone implants, and a great deal of money was awarded to the litigants and substantial financial damage was done to Dow Corning, despite the overwhelming scientific evidence that the implants were safe. In the court of public opinion, silicone breast implants were viewed as unsafe for a substantial period of time, and they are probably still viewed with great concern by potential recipients of implants.

The conclusion I draw from these instances of public controversy over medical treatments is that public opinion rarely moves simply by tracking the scientific evidence; rather, it is formed by a wide variety of factors, especially events such as high profile cases often involving litigation. The point at which the public turns from approval to disapproval is often determined by a variety of basically non-rational factors. Indeed, it is clear that the public is often unmoved by the consideration of scientific evidence. This may have a number of explanations; for instance, scientific expertise seems to be a matter of opinion when it is possible to find "expert witnesses" who are ready to testify for a fee for whatever view is convenient; the decline in science education has meant that the public has only the most feeble grasp of the nature of scientific debate and the enlightenment ideal that rational investigation can lead to the truth; the policy decisions of federal bodies such as the FDA and even national societies such as the American Psychiatric Association seem to be determined at least as much by politics as by principle, and so the public has lost respect for the proclamations of these groups; and so on. It is clear that the media has enormous power in forming public opinion, and it is also clear that most media corporations are driven by the need to make a profit for their shareholders. Which issues get featured and which are ignored is only partly to do with their importance.

So in order to understand how the public debate over Prozac and modern psychiatric medications plays out, we have to take a great many factors into account, and the scientific evidence is certainly not the only relevant consideration. One does not have to be extremely cynical to think that the scientific evidence is often of only secondary importance in the public debate. Factors such as highly publicized trials, cover articles in *Newsweek* and *Time*, reports on the evening national TV news, Hollywood movies and best-selling books focusing on mental illness are certainly as important as the scientific evidence. Of course, pharmaceutical companies are well aware of how public opinion is formed, which is one of the main reasons why they spend so much on advertising their products in the national media.

The role of psychotropic medications in psychiatry is especially liable to spark controversy because it is indisputable that they are potentially dangerous. When patients get their prescriptions filled, the bottles come with warning labels and inserts, setting out the potential side effects and dangers. The lists of possible side effects of most medications listed in the *Physicians' Desk Reference* could alarm the casual browser, and I think that psychiatric medications are in an even more precarious position than other medications when it comes to the court of public opinion, because of factors such as worries about "mind control," the stigma associated with mental illness and the treatment of the "worried well." The regulatory issue is how much risk is our society willing to take, and the public perception of the significance of different kinds of risk can be altered by high profile cases.

Given the somewhat unpredictable ways in which public opinion might shift concerning antidepressants, and the real possibility that the public mood of acceptance and even enthusiasm could be swiftly reversed, it is not surprising that pharmaceutical companies take all steps they can to protect the good reputation of their products. They do not simply rely on scientific results, but promote their products directly through advertising and indirectly through the sponsorship of valuable events such as conferences on the philosophy of psychiatry. Many of the accusations against pharmaceutical companies involve allegations that they have gone too far in trying to manipulate public opinion about their products, through actions such as restricting academic discussion, presenting simplistic models of mental illness in their direct-to-

AAPP Annual Meeting 2003

Psychopharmacology and the Self: Philosophical Questions

May 17 & 18, 2003
San Francisco, CA, 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 2003 Annual Meeting, May 17 and 18, 2003 in conjunction with the American Psychiatric Association Meeting in San Francisco, California. The conference theme is Psychopharmacology and the Self: Philosophical Questions.

Abstracts of 600 words or less and accompanied by the author's name, mailing address, and telephone number should be submitted in triplicate to: Jerome Kroll, M.D., Department of Psychiatry, University of Minnesota Medical School, F282/2A West, 2450 Riverside Avenue, Minneapolis, Minnesota 55454. Phone: 612-273-9814; fax: 612-273-9779; e-mail: kroll001@maroon.tc.umn.edu. Submissions must be postmarked by November 15, 2002. Abstracts will be referred by members of the AAPP Executive Council and their designees, and acceptances will be mailed no later than January 1, 2003. Authors with accepted abstracts will read the corresponding papers at the 2003 Annual Meeting. Accepted papers will be presented within a 30-minute time limit. For further information, contact Jerome Kroll, M.D. at the above address.

consumer advertising, suppressing problematic evidence about their medications, and subverting the processes of legal justice. Psychiatric ethics needs to pay more attention to these sorts of issues, and it should build on the recent attention paid to the conflicts of interest of researchers who depend on pharmaceutical funding to assess the products of pharmaceutical companies. Carl Elliott has recently pointed out that even ethicists can also have conflicts of interest when they too depend on the funding of the drug-industry.

If the media simply reflected the evidence and debate by experts, then there would be little reason to examine for psychiatric ethicists to pay any attention to what happens in the media. But the kind of examples I have already mentioned make it obvious that the interactions between public opinion, media coverage, and expert opinion are highly complex, and bear a great deal of scrutiny. This will help us in assessing the actions of the pharmaceutical companies by placing their actions in a context, with an understanding of all the relevant details. It is even possible that through a better understanding of how public opinion is formed, we might be more able to play an influential role in the public debate over pharmaceutical companies and mental health care.

Both Phillips and Rego mention and apparently endorse concerns that go beyond the question of the safety of antidepressants when prescribed by conscientious psychiatrists. Phillips mentions the tendency of our society to look for a technological fix and the growing influence of the pharmaceutical companies on the field of psychiatry. Rego mentions the prescription of antidepressants by primary care physicians and psychiatrists "without adequate screening, patient education, and follow-up monitoring" which lead to problematic results. This leads me to think that we are in substantial agreement about what the most important issues are in the discussion of antidepressants. Indeed, it seems to me that these are the issues that many critics of Prozac (including even some authors who might be counted among the "Prozac-bashers") have highlighted. What's more, I often find on talking with psychiatrists, other mental health professionals and consumers of mental health services that, although they dislike the rhetoric of some of the more vociferous critics of mainstream psychiatry, they too have deep concerns about the way that antidepressants tend to be prescribed by physicians without psychiatric expertise and the pressures put on physicians by managed care administrators to provide a quick fix. I conclude from this that there should be enough agreement between a wide range of interested groups for the AAPP to lead a very productive debate focusing on the role of antidepressants and other medication in psychiatric treatment. But there will be a practical problem: where can we get the funding to hold a conference on this issue?

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Christian Perring, Ph.D.

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Forum on Bracken and Thomas' "Postpsychiatry: A New Direction for Mental Health"

The following is a discussion of "Postpsychiatry: A New Direction for Mental Health," by Patrick Bracken and Philip Thomas, published in the March 24, 2001 issue of the British Medical Journal. The article, along further discussion, can be found at the journal web site, www.bmj.com. (Click on 'Search/Archives' and enter name of either author.) This forum includes Jennifer Radden's comments in her President's Column in the previous issue of the Bulletin, the following commentaries by Giovanni Stanghellini and Melvin Woody, and finally a response by Patrick Bracken and Philip Thomas to the three commentaries.

JP

Postpsychiatry or social psychopathology?

1. The philosophical background of the crisis of Modernist Psychiatry

The crisis of psychiatry is a crisis of modernism. The negative consequences of the modernist focus in psychiatry are both epistemological and ethical ones: individualism, technology and coercion. All these can be seen as direct outcomes of the philosophy of European Enlightenment. This is the bulk of Bracken and Thomas' (2001) critique of modernist psychiatry.

The first epistemological shortcoming of the modernist focus is *individualism*. Modernist psychiatry separates mental phenomena from background contexts and holds the view that madness is internal. Psychiatric concepts and treatments are focused on the analysis of the singular self. Psychoses and other emotional disorders are described in terms of individual experience. Such descriptions, Bracken and Thomas argue, are rooted in the work of Karl Jaspers (1963), who promoted Edmund Husserl's phenomenology as the framework for psychopathology – i.e. the science of human experience on which psychiatric classifications and practice should be based.

The second problem that arises from such an epistemological framework is the framing of mental health as a *technical issue*. This hyper-technical explanation of madness replaces the "philosophical" (spiritual, moral and political) understanding of madness with technical algorithms, such as standardized classifications and treatment procedures. Estab-

lishing a reliable nosology and evidence-based therapeutic guidelines is today the agenda of "neuroscientific" psychiatrists.

The third negative outcome of the modernist focus in psychiatry is *coercion*. Psychiatric concepts and practice are the products of a culture preoccupied with rationality and the individual self, and the scope of modernist psychiatry seems to be preserving society from the worries generated by irrational agents and incoherent selves. Psychopathology and nosology, as the anachronistic framework for the technical explanation of madness, became legitimate frameworks for coercive interventions.

2. Some philosophical problems in psychiatry

Bracken and Thomas assume that if psychiatry wants to move beyond its modernist *impasse* it should develop an alternative philosophical framework. The crisis of psychiatry is not a technical but a philosophical one. We all agree that the psychiatrist is confronted, because he is called upon by his patients and by the role attributed to him by society, with questions always tackled by philosophy.

On a strictly psychopathological level, for example, delusion recalls the problem of truth, hallucinations that of reality; the guilt of the melancholic is an inevitable reference to the problem of good and evil, and suicide recalls the problem of free choice. Is it possible to treat while ignoring adequate philosophical references, epistemological and ethical aporia with which the human consciousness grapples (often unknowingly), or while underestimating the existential importance of such questions in the lifeworld of the patient in postmodern society?

In his institutional role, moreover, the psychiatrist is called to make decisions that would demand specific knowledge of ethics applied to the bio-medical disciplines. One example among many, that of forced treatment, a measure that drastically reduces the person's individual liberty to give or withhold consent to mandatory treatments. The psychiatrist often finds himself between the devil and the deep blue sea: an abuse would stand for false imprisonment on one hand and the incompetent patient's surrender on the other. The prison abuses of psychiatry in totalitarian regimes - this Shoa in errant and dissenting consciousness - are a painful legacy that the last century has left us; whereas the city's underground (train stations and subways) bears witness, on the contrary, to how the sacred union between madness and marginalisation expends itself in the so-called liberal countries, thanks to budgetary health policies.

Another example of philosophical problems implied in today's psychiatric debate is: how will the eugenic risk be dealt with in the human genome project? On what ethical presuppositions, on the basis of what conception of the *condicio humana* will the limit between vulnerability and illness be established? Will it be possible to evade or dispose of general assertions of principle, the problem of bio-eccentricity - of the relationships between vulnerability to schizophrenia, schizophrenic illness and creativity? Will it be finally possible to grant adequate attention (and adequate financing) to those studies that seek to establish the characteristics of divergent, hyper-inclusive and allusive thought - or, as it is said today, "trans-liminal" thought - that unites the schizophrenic ill with that category of people capable of completing cognitive acrobatics that reveal connections between elements that logical-rational thought doesn't see and that instead allow the achievement of original solutions to old problems?

There is also the problem of the use and abuse of medical treatments in so-called vulnerable persons. This is a very practical and compelling problem: that of the use of drugs in so-called sub-clinical or "under the threshold" conditions. It deals with intermediate conditions between normality and supposed vulnerability to real mental illnesses (emotional disorders such as, for example, depression); conditions, therefore, whose treatment hovers between forced normalization on one hand and real prevention on the other. This kind of choice doesn't involve the individual physician and his patient, but is placed in a horizon that incorporates the concept of normality and illness, the image of man passed or failed by a psychiatry that has social adaption or individual well-being, social expectations and the interests of pharmaceutical companies that condition research, as its objective. Here one no longer speaks only of the treatment as medical category, but of the treatment in itself as a way in which each man enters in relationship with himself, thinks of himself and knows himself, chooses and chooses himself. Here one speaks of the way in which man thinks of his body, the dark source of his feelings, his moods, of feeling himself attracted or rejected, interested or bored. Is boredom an illness? Who should answer this question? And on the basis of what assumptions, medical, psychopathological or philosophical?

3. What philosophers can teach to psychiatrists and what philosophers can learn from psychiatrists

Psychiatrists not only need the good advice of philosophers, but also the errors of philosophers. The in-depth knowledge of some philosophical systems or positions that ominously resemble some psychopathological conditions could throw open an unexpected dimension of understanding of mental pathology - and in psychiatry "understanding" is the fundamental presupposition of "treating." This is true for stoicism (the withdrawal from a divided and unlivable world), skepticism (the attempt to argumentatively annihilate the differentness of the world), and idealism (the belief that the world is my own representation), for example (Berthold-Bond 1995). Not a few philosophers - and among these above all Wittgenstein - have conceived their own philosophy as a real cure of the errors of the philosophers that preceded them. The illness that grips most philosophers, for which Wittgenstein searches a remedy, is solipsism - the doctrine according to which reality is nothing other than a representation rendered possible by a thinking individual and that is destined to dissolve as soon as the individual itself dis-

solves. Isn't this the same metaphysical stupor in front of which a lot of lives that we define as "schizophrenic" come to a halt? From the "diagnoses" of the philosophers, and relative "treatments," psychiatrists have a lot to learn.

Not only do psychiatrists need philosophers, but philosophers also need psychiatrists. If the objective of psychiatry is, in the first place, to understand the condition of the sufferer facing him, that of philosophy is the understanding of the human condition in general, in which suffering (and madness) play a fundamental role. "Madness is a necessary stage in the development of the spirit." These are Hegel's words (1959), which in a single blow erase the idea that madness is pure nonsense, the negation of man's humanity. To the contrary, Man does not exist without the possibility of madness. Vulnerability - that is the condition of the possibility of madness - and the human condition correspond: eccentricity, non-correspondence with oneself, lack of an objective correlative to one's own identity, incompleteness as destiny of a perpetual becoming, duplicity as condemnation to liberty represent the formal structure of the humanity of Man and Madness (Stanghellini 2000a). Therefore, starting with Hegel and culminating in the philosophies of the twentieth century (from phenomenology to existentialism to Wittgenstein), in philosophy abnormal phenomena are those "who wear trousers" and therefore point to the main road in the understanding of man.

4. Postpsychiatry or social psychopathology?

Postpsychiatry - Bracken and Thomas argue - emphasizes social and cultural contexts, places ethics before technology, and seeks to minimize control and coercion. I fully agree with this agenda, but for one point: its harsh criticism of phenomenology. For Bracken and Thomas, Husserl's phenomenology and its applications in psychopathology are products of modernism and as such tackle the postmodernist project. I think they are wrong on this issue.

Different trends in phenomenology have advanced profound reservations concerning early phenomenological attempts to develop a theory of experience (especially of the experience of the other) based on the analysis of isolated individuals. All of Husserl's (1950, 1959) work is marked by an unresolved tension between egological phenomenology and a social phenomenology (Zahavi 1996). Recently, the egological perspective - the individual mind being the site of the original creation of socially shared meanings - has been completely abandoned. This leads to two fundamental consequences (Stanghellini & Ballerini, in press):

1) The nature of knowledge (the meaning and explanations that each of us gives to her own experience) becomes necessarily conventional and derivative from society. This is where one can clearly trace social constructivist features (Berger & Luckman 1966).

2) The phenomenon of intersubjectivity is considered as a primordial event, and not as a category that must be attained starting from the solus ipse (or "transcendental ego"). As a consequence, social phenomenology abandons the naive belief that reality is ontology. We experience objects and events as "real" because we share their meanings with others. The social world is the world of meanings shared by individuals who are part of it.

According to phenomenology, on the one hand it is wrong to adopt a model of social interactions that bypasses the analysis of subjectivity during the process of the constitution of meanings (as behaviourism and functionalism do). On the other, (as symbolic interactionists have observed) it is also wrong to separate the individual mind from social phenomena as we analyze the processes through which we attribute the meanings to objects and events.

Facts, events, and objects of the world (and in general every social fact) are not considered realities that are independent of the individuals' mental activity, but as phenomena - i.e. contents related to intentional minds (the individuals' mental activities). Phenomenology has defended this inescapable subjective peculiarity of sociality, adopting as its landmark the subjective dimension of social action and the forms of symbolic mediation operated by the mind during the process of interaction among individuals. The social world is the world made of meanings understood and shared by every individual. The constant reference to the subjective dimension does not appear only as a fundamental epistemological argument, but throughout this model it also adopts a full ethical choice feature (Schutz 1936, 1973; Berger & Luckmann 1966; Garfinkel 1967; Natanson 1970).

The analysis of subjectivity as a social phenomenon has been the fruitful epistemological basis for social psychopathology whose aim is the clarification of the impairments of intersubjectivity in mental disorders, and especially in melancholia and in schizophrenia (Blankenburg 1971; Kraus 1977; Stanghellini 2000b and in press). Phenomenology is not merely the analysis of a singular self truncated from society; and not all psychopathology is concerned just with the disorders of individual experience, separate from background contexts. Would Bracken and Thomas consider all this while developing their project?

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Psychiatry and its Discontents

Are there any psychiatrists who are contented with the state of their art? I have yet to meet one. Criticism abounds - and those lodged by Bracken and Thomas are quite familiar. The novelty in their critique depends upon their annexation of their complaints to a theory about the history of the West since the eighteenth century. They embed their criticisms of psychiatry in a theory about the transition from "modernity" to the "postmodern" condition. I leave it to psychiatrists to assess the force of their several criticisms of "modernism" in psychiatry, which have often been raised independently of this historical theory, and will concentrate my response upon the philosophy of history to which they annex those criticisms.

Since the transition to "postmodernity" presumably took place some time during the last century, it will be convenient to follow their lead and take Karl Jaspers *General Psychopathology* as a point of departure, since that work first appeared in 1913, on the eve of the first world war, and went through six further editions by 1959[1] Bracken and Thomas begin their critical analysis by contrasting the demands of post-modernity with Jaspers' account, which they regard describe as exemplary of "modernism". If their historical thesis is correct, their critique should be distinctively "post-Jasperian." If times have changed as significantly as they urge, we cannot expect to find their primary critical points already developed in Jaspers' account.

Unfortunately, their brief discussion of Jaspers shows a rather scanty acquaintance with his *General Psychopathology* and a very sketchy understanding of the phenomenological tradition. As Salman Raschid pointed out in his response to their essay in BJM, they exaggerate Husserl's influence upon Jaspers and misconstrue Husserl's transcendental reduction as separating the mind from the world and "'bracketing out' contextual issues."[2] "In this theoretical tradition," they write, "the mind is understood as internal and separate from the world". But even though Husserl invited such a Cartesian reading in some passages, Jaspers explicitly rejects any such construction within the first few pages of his "Introduction," where he insists that the mind is always in the world. He distinguishes between the private world of any individual organism and the "general world, common to all," and concludes that, "there is a basic relatedness between what is within and what is without; we are in a world common to all living things and to all psychic life and to every human being in his separate reality."

Bracken and Thomas later urge that postpsychiatry should progress from Jaspers' phenomenological approach to the hermeneutic method inspired by Wittgenstein and Heidegger. But Jaspers is famous for insisting that psychiatry must rely upon hermeneutics, upon "Verstehen" or interpretative understanding as contrasted with the explanatory methods of the natural sciences. Indeed, even his account of the role of phenomenology in the *General Psychopathology* confines it to the first chapter and insists that the phenomena of interest to psychopathology are only accessible through hermeneutics, through interpretation of what patients say and do, since we can have no direct access to their experience. This also highlights Bracken and Thomas's confusion in complaining that Jaspers insists that phenomenology "separates the form of a mental symptom from its contents" and is interested only in the form. Had they heeded their own insistence upon the importance of attending to context, they would have noticed that Jaspers ends the passage in the *General Psychopathology* from which they quote by observing that, "Phenomenology finds its major interest in form; content seems to have a more accidental character. But the psychologist who looks for meaning will find content essential and the form at times unimportant." And Jaspers turns to that search for meaning in Part II of the *General Psychopathology*, which deals with "The Psychology of Meaning -- *Verstehende Psychologie*." He only turns to the method of causal explanation modeled upon medicine and the natural sciences in Part IV, *after* nearly two hundred pages devoted to meaningful objective phenomena and the interpretative or hermeneutic method, both of which must be distinguished from phenomenology.

Bracken and Thomas criticize "modernist" psychiatry for seeking "to replace spiritual, moral, political and folk understandings of madness with the technological framework of psychopathology." They cite psychopharmacology, neuropsychiatry and DSM IV as exemplifying this optimistic belief "that human suffering would yield to the advance of rationality and science." Unfortunately for their historicist thesis, Jaspers developed these same themes in some detail. Like Bracken and Thomas, he acknowledges that some mental illness can be traced to somatic causes. But the introduction to *General Psychopathology* warns against "the somatic prejudice," which tacitly assumes that, "there is no need to investigate the psyche as such; it is purely subjective. If it is to be discussed scientifically, it must be presented anatomically, somatically - as a physical function." Jaspers ends his dismissal of this prejudice by quoting Janet: "if we are to think anatomically where psychiatry is concerned, we might as well resign ourselves to think nothing." As for DSM III and IV, they had yet to be devised when Jaspers wrote. But in his chapter on psychiatric nosology, he mounts a sustained critique of the psychiatric taxonomies extant at the time, warning against the dangers of attempting to conceptualize all the variety of human distress and folly in terms of "disease entities," "symptom complexes" and "diagnostic schemata." He is equally clear about the limitations of "rationality and science."[3]

Like Bracken and Thomas, and long before the advent of "postmodernism," Jaspers warns against focusing too much upon rationality[4] and the individual self abstracted from his social, cultural and institutional context.[5] And he is well aware of the origins of psychiatry in coercive institutions, which they represent as one of the key recognitions and concerns of "postpsychiatry."[6] He describes how this was bound up with the elevation of the medical model of knowledge derived from the natural sciences to the status of an absolute knowledge of man as a whole. But although he has argued against such a

limited understanding of human beings for reasons very like those cited by Bracken and Thomas, Jaspers acknowledges that it provided the rationale for more humane practices, even though it could never prove theoretically or therapeutically adequate.

So, what's new? All of the criticisms of psychiatry that Bracken and Thomas develop can already be found in Jaspers *General Psychopathology*, as are their pleas for a more hermeneutic approach and for a culturally context-sensitive and ethically oriented psychotherapy that attends to the voices of the patients. These seem to be perennial criticisms and concerns rather than peculiarly recent or "post-modern." That certainly doesn't mean that they aren't legitimate. (On the contrary! Their durability argues for their significance and testifies to the difficulties of meeting them.) "What's new" is the specific horizon of difficulties that psychiatry faces today in comparison with the prospect that Jaspers envisioned in 1913 - or 1959. When Bracken and Thomas turn from criticism to sketching "a new direction for mental health," they begin and end by asking about how to foster mental health outside the coercive settings of the asylums and hospitals that gave birth to psychiatry. "Post-modern" turns out to mean "post institutional" or outside the hospital. Writing before the introduction of tranquilizers and antipsychotic medications, Jaspers did not foresee the emptying of the mental hospitals that began about the time of the publication of the 7th edition of his *General Psychopathology*. He acknowledged that "Rational treatment is not really an attainable goal as regards the large majority of mental patients in the strict sense. There can only be protection of the patient and society through hospital admission and every possible therapeutic measure exercised in the care of the patient." (840). Acknowledging that hospitalization is often involuntary and that the institutional setting shapes the experience of the patient along with the diagnosis and treatment, Jaspers evidently assumed that long term hospital care would remain both necessary and available. He could hardly anticipate a world in which psychiatrists do battle with insurance companies and HMO's in order to stave off the discharge of their patients within a week, or to provide any extensive therapy beyond prescribing the pills that made the depopulation of the hospitals possible. Meanwhile, the number of hospitals that even offer voluntary long term psychotherapy has dwindled so drastically that it is hard to know where to place a patient who needs it.

Under these circumstances, one may well seek new directions for a post-institutional psychiatry, especially one that would look beyond the "somatic prejudice" in order to explore "the web of meaningful connections" that bind "the events, reactions and social networks" of a patient's life into a whole "that defies causal analysis," as Bracken and Thomas urge. But the evidence at hand does not seem to support a diagnosis that traces the dis-ease of contemporary psychiatry to a "modernism" infected by the Enlightenment. Bracken and Thomas would do better to turn their attention to the current institutional setting of psychiatry, which has relocated the centers of exclusion and control from the hospital and clinic to health management organizations and insurance plans, whether state or commercial and to the substitution of Prozac and Ritalin for the straightjackets and shackles of yore. These are the new realities that shape the treatment of mental illness and that have redefined the perennial sources of psychiatric discontent.

Endnotes

1. Jaspers' last extensive revision of the *General Psychopathology* was to the fourth edition of 1942. By that time, the Nazi government had forbidden him to teach or publish. In any case, by that date, he had already moved from psychiatry into philosophy and after the war, he could not see his way clear to turn away from philosophy in order master more recent research and to "live for a while in a clinic in order to refresh and extend my own experience," as he explains in the preface to the seventh edition of 1959. (xii)

2. As Salman Raschid pointed out in his response to their essay in BJM, they exaggerate Husserl's influence upon Jaspers and misconstrue Husserl's transcendental reduction as separating the mind from the world and "'bracketing out' contextual issues."

3. Indeed, the analysis of these limitations became a central theme of Jaspers thought once he turned from psychiatry to philosophy. The first volume of his *Philosophie* explores the nature and limits of the objective, scientific understanding of the world. The second and third volumes dwell upon all that *that* view excludes.

4. "In actual fact, rational behaviour plays a very small role in human affairs. Irrational drives and emotional states usually prevail, even when the individual wishes to convince himself that he is acting on purely logical grounds. Exaggerated search for rational connections gives rise to intellectualizing , which obstructs any hope of reaching a true and penetrating understanding of human behaviour. Reasoning is then overrated as against the forces of suggestion. When the patient appears irrational, there is a hasty resort to a diagnosis of 'dementia' and all the complex richness of human experience is ignored" (19).

5. "Man lives by participating in the collective cultural achievements of history and only reaches his own individual development through them." (15). Jaspers devotes Part V of *General Psychopathology* to the "Social and Historical Aspects of the Psychoses and Personality Disorders". If anything, he attends more to broad historical and social factors than to the family, which receives surprisingly scant attention in his discussions.

6. "The *hospital institution* is a world of its own. Its 'atmosphere' is determined by the attitudes of management and the doctors and the traditional opinions held. The institutional milieu creates a particular world. The order which prevails determines the picture which the disorders assume." (841). Then, after commenting on how different institutional forms shape the roles and experience of patients and staffs, Jaspers remarks, "There always remains the basic fact of *compulsion*.... A great step forward was made when Pinel 'freed the made from their chains,' Jaspers remarks that "But the development of institutional treatment in the nineteenth century, though it did indeed do away with this repulsive picture, still saw the place of chains taken by scopolamine injections and continuous baths, and the bared cots and solitary confinement could not be dispensed with entirely. The old clutter of torturing instruments could be thrown away and the spirit of the institution underwent change but the basic principle of compulsion could not be done away with." (842)

For the origins of psychiatry in the mental hospitals, see. p. 846, where Jaspers comments upon the medicalization of the treatment of the insane and the emergence of psychiatry from those institutions.

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Authors' Response to Commentaries

We are grateful to the editor for his invitation to respond to the commentaries of Radden, Woody and Stanghellini. In turn, we are pleased that these authors have taken the time to reflect upon our article that was published in the *British Medical Journal* last year (Bracken and Thomas, 2001). The first thing to say is that the BMJ piece was very much a condensed account of our ideas. The article was deliberately polemical and included a number of 'broad brush-strokes' for which we have been taken to task. We are currently writing a book on the subject. Hopefully, the book will allow us the space to express our thoughts in greater detail. The three commentators for this Bulletin all agree with us that psychiatry needs to change. They are agreed that the discipline has serious problems and all welcome new thinking for the 21st century. Their critiques emerge from different perspectives and we shall deal with each separately.

Jennifer Radden is clearly in sympathy with the clinical implications of our approach and states: 'that biomedical psychiatry fails the mentally ill in many of the ways adduced by Bracken and Thomas, is undeniable'. In spite of this, she is uncomfortable with our derivation of this critique. Radden wants to defend the role of Enlightenment ideas in improving the care of those now regarded as mentally ill. She argues that Enlightenment concepts such as the idea of 'human rights' have made a positive contribution to the situation of such people. This may be so. We acknowledge the long history of resistance to oppression and domination within the field of mental health. Radden is correct to argue that some of this has drawn on Enlightenment ideals such as human rights and dignity. We do not argue that nothing of positive value emerged from the Enlightenment. It is more that we cannot assume that all developments stemming from this cultural shift were for the good. Foucault speaks about the 'intellectual blackmail' of having to be 'for or against the Enlightenment' (Foucault, 1984, p. 45). Furthermore, we question the idea that the Enlightenment was a singular, unidirectional movement. Postmodern theory involves not a rejection of Enlightenment but a realisation of its complexity, its contradictions and limitations.

Such complexity is manifest in the history of the famous York Retreat. On one level the reforms introduced by the Tukes were very much centred on a belief in the therapeutic power of reason. But on another level their efforts involved a rejection of medical science and were driven in large measure by their religious faith and their belief in the power of community and friendship. As the historian Roy Porter wrote:

> The Retreat was modelled on the ideal of family life, and restraint was negligible. Patients and staff lived, worked and dined together in an environment where recovery was encouraged through praise and blame, rewards and punishment, the goal being the restoration of self-control. The root cause of insanity, physical or mental, mattered little. Though far from hostile to doctors, the Tukes, who were tea merchants by profession, stated that experience showed nothing medicine had to offer did any good. (Porter, 1997, p. 498)

The Retreat certainly drew on key Enlightenment ideas about the importance of rationality, but to us it also provides an example of how progress in the area of mental health has often been driven by a heightened ethical sensibility rather than a focus on science or technology. One of the key elements of what we are calling postpsychiatry involves a 'placing of ethics before technology'. By this we mean a search to put ethical issues–respect, dignity, empowerment and the importance of relationships–at the heart of our work, both theoretical and practical.

To a large degree, in the late 20th century, medical progress came to be equated with new forms of technology. This agenda served professional and corporate interests very well and did bring some benefits for patients. However, it also had a downside. For example, the wealth and power of the pharmaceutical industry has resulted in an increasingly narrow vision within psychiatry. Non-biological responses to madness and distress have become progressively more marginalized. On an international level the modernisation of health services is largely understood simply to involve access to new drugs and other technologies. In other words, the quest for medical modernity has become allied to the march of corporate capitalism. Our call for 'ethics before technology' is a call to put the brakes on. But let us be clear: we are not against technology. Drug treatments are a part of our day-to-day practice. But they are not the central part. Furthermore we use these drugs with a sceptical view of what they offer and the 'information' that accompanies them. Postmodern theory nurtures this scepticism. Its radical questioning of grand narratives stands in stark contrast to the triumphant (and well funded) arrogance of current advocates of simplistic biological models.

We accept that there are other discourses, some derived from Enlightenment thought, from which one could launch an attack on these developments. For example, Marxist theory can illuminate the relationships between economic forces, medicine and the state. The sort of postmodern theory we turn to would not deny this. What we reject are forms of Marxism (and other critical discourses) that claim to have found a singular pathway to the truth. Our understanding of postmodern thought is close to that of Barry Smart when he describes a "form of reflection upon and a response to the accumulating signs of the limits and limitations of modernity. Postmodernity as a way of living with the doubts, uncertainties and anxieties which seem increasingly to be a corollary of modernity, the inescapable price to be paid for the gains, the benefits and the pleasures, associated with modernity" (Smart 1993, p.12).

Like Radden, Melvin Woody denies that the problems of psychiatry are bound up with its endeavours to establish itself as a modernist enterprise. Instead he urges us to attend to the 'current institutional setting of psychiatry'. We are very aware of this setting. However, for us, it is precisely psychiatry's self-understanding as an enterprise of modernity, bringing science and technology to bear on areas of human life that were previously private or more the territory of families and priests, that is the door through which the drug companies and others have entered the field. Patients and healers are now ruled by an alliance of professional psychiatry and large corporations. The language through which this alliance is cemented is the language of positivist science, technological progress and modernisation. Our turn to postmodern theory represents an attempt to forge a critique that is adequate for our times.

Woody also tackles us with regard to our understanding of Jaspers. He insists that the central elements of our critique are already present in Jaspers. To some extent he is correct. We share with Jaspers a concern with meaning and like him reject models based on biological reductionism. We agree that a large part of the *General Psychopathology* (Jaspers 1963) is about *Verstehende Psychologie* (psychology of meaning). Our dispute with Jaspers is not around the question of meaning but rather with his characterisation of phenomenology. In the *General Psychopathology* this is presented as something separate from the question of

meaning and interpretation. He says: 'Phenomenology is for us purely an *empirical method of enquiry* maintained solely by the fact of the *patients' communications*' (p.55, original italics). It is a form of descriptive psychology. While both are necessary for an adequate psychopathology, phenomenology and hermeneutics are nevertheless distinct methods. In maintaining this separation we believe that we are correct in our assertion that Jaspers walks in the footsteps of Husserl.

As Woody will know, there is an ongoing debate about the extent to which Jaspers's philosophy was influenced by Husserl. The consensus has been that Husserl had a substantial influence on Jaspers, at least with regard to his understanding of phenomenology. More recently, German Berrios (e.g. 1993) and Chris Walker (e.g. 1988) have challenged this interpretation in different ways. In turn, Osborne Wiggins and Michael Schwartz (e.g. 1997) have disputed *their* readings of Jaspers. For our part, we believe that there can be little doubt that the approach to phenomenology in the *General Psychopathology* was derived from the early work of Husserl. Jaspers says so himself in the sentence following that quoted above. He writes: 'Husserl used the term initially in the sense of a 'descriptive psychology' in connection with the phenomenon of consciousness; in this sense it holds for our investigations also ...' (Jaspers, 1963, p.55). For Jaspers, phenomenology involves a descriptive listing and definition of various psychic states. It involves a 'static' grasp of psychic phenomena. In contrast, understanding the meaning of these phenomena demands a 'genetic' methodology. These are concepts also derived from Husserl. While Woody is correct in his assertion that Jaspers believes that both approaches are necessary for a proper understanding of psychopathology, he fails to appreciate the importance of the separation made by Jaspers. We believe that it was only with Heidegger's *Being and Time* that phenomenology and hermeneutics truly came together. For Heidegger, phenomenology is an ontological not an empirical enterprise. It involves both a gradual illumination of Dasein as being-in-the-world and a struggle with the meaning of being itself. This is far from the 'descriptive psychology' of Jaspers's early work. In Heidegger's work phenomenology *is* hermeneutic.

Woody also joins Salman Raschid in disputing our characterisation of Husserl's transcendental reduction as having echoes of Descartes' *Meditations*. By way of retort let us quote Heidegger (quoting Husserl) from *The Basic Problems of Phenomenology:*

> [The] distinction between subject and object pervades all the problems of modern philosophy and even extends into the development of contemporary phenomenology. In his *Ideas,* Husserl says: "The theory of categories must begin absolutely from this most radical of all distinctions of being - being *as consciousness* [*res cogitans*] and being that 'manifests' itself in consciousness, 'transcendent' being [*res extensa*]." "Between consciousness [*res cogitans*] and reality [*res extensa*] there yawns a veritable abyss of meaning." Husserl continually refers to this distinction and precisely in the form in which Descartes expressed it: res cogitans - res extensa. (Heidegger, 1982, pp 124-125, Heidegger's italics and brackets).

Woody argues that Jaspers advocated for a form of psychiatry similar to that which we have proposed as postpsychiatry. A second key element of postpsychiatry is an attempt to reorient mental health theory away from a Cartesian (epistemological) understanding of mind towards a Heideggerian (ontological) form of phenomenology. The former has an intrapsychic focus, the latter gives priority to questions of context. For us, Jaspers's position in this debate is too ambiguous to ground a substantive critique. His presentation of phenomenology in the *General Psychopathology* has allowed 20th century psychiatry to turn it into a sort of tool to examine the patient's psyche. His definitions have become the spectacles through which psychiatrists encounter the worlds of their patients. In his foreword to the English translation of the *General Psychopathology,* Anderson writes that '... the phenomenological approach involves painstaking, detailed and laborious study of facts observed in the individual patient at the conscious level' (Anderson, 1963, p. vi). This is the precisely the understanding of psychiatric phenomenology that we are trying to overcome.

We hope that the above comments concerning phenomenology will also serve as a response to the commentary of Giovanni Stanghellini. Of all the commentators Stanghellini is the most supportive of our project. However, he believes that a 'social psychopathology' grounded in 'the phenomenon of intersubjectivity' could be a better framework for launching a new approach. From what we have said above it should be evident that our quarrel is not with phenomenology as such. In fact, our work (e.g. Bracken, 2002) is substantially influenced by Herbert Dreyfus' presentation of Heidegger's phenomenology (Dreyfus, 1993). But phenomenology is not enough. Any critique of psychiatry must grapple with the question of power and the history of the institution. Otherwise there is a danger that it becomes an intellectual exercise or, worse, becomes incorporated into the governing discourse. This is where the ideas of Foucault are important. Much of Foucault's work has been concerned to demonstrate the constructed nature of some of our most established assumptions. Our notions such as selfhood, sexuality and reason are shown in his work to be historically contingent 'cultural products'. Foucault's aim is to show that the order produced in our lives by such givens is not established without cost. This is an agenda shared with other postmodern writers such as Derrida and Bauman. Stephen White writes that Foucault shares with other postmoderns: "a strong sense of responsibility to expose and track the way our modern cognitive machinery operates to deny the ineradicability of dissonance. The harmony, unity, and clarity promised by this machinery have, for the postmodern, an inevitable cost: and that cost is couched in a language of the Other that is always engendered, devalued, disciplined, and so on, in the infinite search for a more tractable and ordered world" (White, 1991, p.20). Thus emerges what White calls a 'responsibility to otherness'. This involves a concern *not* to impose order on the world but instead to allow the emergence of other voices and visions even when this involves increasing complexity and ambivalence.

In the end postpsychiatry is a rhetorical device: a word coined in an attempt to imagine something different. It is not about a new theory or a new model. It is rather meant as a statement that mental health work is possible without the theoretical or practical framework of traditional psychiatry. Foucault suggested that we should 'envisage modernity rather as an attitude than as a period of history' (Foucault, 1984, p. 39). In similar vein postpsychiatry is not a search for a new system but an effort to promote a 'post-modern' attitude, or sensibility, towards madness and distress. We see this sensibility at work already in many elements of the service user movement. This movement is gathering strength by the day. It is not our place to tell service user organisations in which direction they should travel. Our task is about opening up the currently dominant discourse to

analysis and critique, thereby creating a space in which other voices are heard. Philosophy has an essential role to play in this endeavour.

We believe that philosophical ideas have always been deeply involved in the development of psychiatry. Its guiding assumptions and the challenges to these have drawn directly and indirectly on philosophies of different hues. Postpsychiatry is an attempt to forge a critique of psychiatry that draws on some of the philosophical ideas available to us at the beginning of the 21st century. For us, the insights of postmodernist thought should be seen as adding to previous critical positions, not as an attempt to establish a new canon with its own truths.

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The Association for the Advancement of Philosophy and Psychiatry was established in 1989 to promote cross-disciplinary research in the philosophical aspects of psychiatry, and to support educational initiatives and graduate training programs.

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