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

Bulletin

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From the Editor

In the engagement of philosophers with clinical psychiatry the pre-eminent figure has been Karl Jaspers, who was a psychiatrist before turning to philosophy, and who wrote the justly acclaimed *General Psychopathology*. Less known is the engagement of his one-time friend and colleague, Martin Heidegger. In the post-war years Heidegger responded to a letter from a Swiss psychiatrist and psychoanalyst, Medard Boss. A friendship and collaboration followed that lasted to the end of Heidegger's life in 1976. For a ten-year period from 1959-1969 Heidegger traveled to Boss's Zollikon residence outside of Zurick several times per year for two-week seminars with fifty to seventy psychiatrists and psychiatrists in training. In writing about the beginning of their relationship, Boss notes: "Only much later did I discover the most important motive for Heidegger's prompt answer to my first letter. From the very beginning, as he himself once admitted, Heidegger had set great hope on an association with a doctor....He saw the possibility that his philosophical insights would not be confined merely to the philosopher's quarters but also might benefit many more people, especially people in need of help."

In 1987 Boss published in German a volume that includes the seminar protocols, corrected and emended by Heidegger, notes of conversations between Heidegger and Boss outside the seminars, and extensive excerpts from Heidegger's letters to Boss from 1947-1971 (*Zollikoner Seminare, Protokolle–Gespräche–Briefe. Herausgegeben von Medard Boss.* Frankfurt am Main: Vittorio Klostermann, 1987). The v.olume was translated into English by Frantz Mayr and Richard Askay and published, with afterwords and notes by the translators, in 2001 (*Martin Heidegger: Zollikon Seminars. Protocols–Conversations–Letters*, Edited by Medard Boss. Evanston: Northwestern University Press). The volume has not attracted a lot of attention, an exception being William Richardson's "Heidegger among the Doctors" (in *Reading Heidegger: Commemorations*, ed. John Sallis. Indiana: 1993), which should be read as another preface to the volume.

Reviewing the *Zollikon Seminars* poses several questions. Who is the intended or possible audience? Does the volume offer something to clinicians without previous familiarity with Heidegger's philosophy? Do the discussions offer something to clinicians who do enjoy a familiarity with the philosophy? Given the frequent discussion and critique of psychoanalytic concepts by Heidegger, does the volume have a place in the ongoing discussion of the status of psychoanalysis? Finally, for those (like this writer) who are not enamoured by Boss's writings, which were very directly influenced by Heidegger (as is quite evident in this volume), do the discussions by Heidegger provide more than can

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President's Column

(Our president, Jerry Kroll, is currently on medical leave, and this column is written by our ex-president, Jennifer Radden. – Ed.)

The findings of President Bush's New Freedom Commission on Mental Health were announced earlier this year: the Commission recommends "transforming how mental health care is delivered in America," and speaks of overcoming barriers through "resolve and leadership." The Commission's 100-page report has received praise from several quarters, including the Health and Human Services Secretary Tommy Thompson. What's not to like about it, at first sight? In reforming mental health care policy the states are charged with replacing the present uneven and inadequate system of care with a comprehensive, community-based network of services sufficient to transform every mentally ill person into a productive, independent citizen rising above disability in an atmosphere where stigma and discrimination are things of the past.

Well, amen to that. But the report offers a hodge-podge of observations, case 'demonstrations,' recommendations and platitudes about mental illness which, on closer scrutiny, proves much stronger on pious hopes than realistic goals. And—though responsibility for mental health policy has been placed squarely in the hands of the states—the kind of 'wrap around' community based care which it recommends is almost certainly going to impose a financial burden which the states cannot shoulder unaided.

I must also take issue with Secretary Thompson's characterization of this report as "thorough and thoughtful." It seems to me neither. It offers an uncritical embrace of ideas, assumptions and theories which, because they are the subject of ongoing controversy, require very careful explication and a reasoned defense. True, this was a report, not a scholarly dissertation. But at the least, a report which was thorough and thoughtful would have tempered its enthusiasm by acknowledging that controversy attaches to its claims. The application of the disability model to mental disorder, an application popular today through a convergence of interests of the consumer movement and the drug companies, but not without its problems and paradoxes, is an example. The disability model applauds and rests on the very rational autonomy which becomes dubious when we speak of mental illness. The ongoing controversy over the biological model in psychiatry, which goes similarly unacknowledged here, is another; the Commission's report lauds biological psychiatry unguardedly. The report emphasizes early screening and treatment, yet these are also controversial: there are many who are concerned over the early diagnosis of children and some, even among the researchers themselves, who question claims that earlier intervention improves outcomes. One of the most serious concerns about psychopharmacology, the question of its side effects and long term effects, is dismissed in a paragraph. Finally, the simplistic solutions to stigma (more public education) fail to address the deep

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historical and cultural roots of prejudice about a condition depriving its sufferers of traits valued in our culture, such as reasoning capability and self control. A passing look at reform movements since the eighteenth century suggests that the eradication of stigma and discrimination may not be so easy. The Commission's reform is in an historical vacuum. It is also in an international vacuum. Case 'demonstrations,' often on a tiny and impossibly modest scale, reflect no hint that anywhere else in the world useful policy solutions to these same problems might have been proposed, or even tried.

On the positive side, emphasis on the consumer movement fits with the latest thinking in this and other countries. Involving consumers in their treatment is the first step, as this report rightly sees, and some of the small experiments in 'wrap around' care are proving an exciting and promising alternative model of mental health care. Even if it is overly optimistic and unrealistic, and if the states cannot be expected to go it alone, the President's Commission on Mental Health offers a laudable set of goals for twenty-first century psychiatry.

Jennifer Radden, D. Phil.

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AAPP Annual Meeting 2003

The Fifteenth Annual Meeting of the Association for the Advancement of Philosophy and Psychiatry which met May 17-18, 2003, provided audiences with a diverse range of approaches to its theme 'Psychopharmacology and the Self,' in a series of thought provoking presentations representing several different disciplines - not only philosophy and psychiatry, but also psychology, psychoanalysis, literary criticism, the history of medicine, and the social sciences.

The meeting was arranged around presentations by two keynote speakers, distinguished philosopher Richard Wollheim, Professor Emeritus at the University of California at Berkeley and author of many works on psychoanalysis, the mind and the self, and Professor W. John Livesley, MD, PhD., of the University of British Columbia, renowned researcher and editor of the *Journal of Personality Disorders*.

After providing a breathtakingly succinct précis of psychoanalysis, Wollheim settled onto a series of questions about ideals of self knowledge, self identity, and desire. Believing is "transparent on" belief in a way not shared by desiring and desire, he showed (I may desire P without believing P worth desiring). Thus, questions about self knowledge which involve our desires are more complex, and more integral to identity than those involving belief, engaging our sense not only of how we are, but how we would like to be, and the two ideals of self acceptance, and self improvement, respectively.

Livesley's focus was the unity and coherence of the self understood as the product of hierarchically organized schemas developed over time and necessary for functioning. Presenting the self as an organizing construct, he expounded on the structural and functional features providing the sense of the self's coherence, and the failures of these mechanisms which result in the fractured self of personality disorders. Illustrating such failures of integration with case material, Livesley cited data suggesting that psychopharmacology sometimes can effect this integration.

The papers which followed ranged between the highly abstract and theoretical, the concrete and case based, and the socially informed and political. They reflected the distress of clinicians forced, in the words of Phil Sinaikin, MD, under "the looming and constant presence and control of the DSM model."They acknowledged, in their various ways, the lessons of 'listening to Prozac' in an 'anti-depressant era.'

Some of the implications of psychopharmacology to the self were raised by Jim Phillips, MD who, in clarifying the relation between the affective and cognitive self pointed to the profound effect of antidepressants on mood, and thus on the deeper, affective self.

In his exploration of personal identity and personal agency, Christian Perring evaluated degrees of personality change in light of questions like "Would it still be me ?" and "Which of your actions are really your actions ?" In doing so he highlighted the complexity of the identity criteria employed in such judgements. Gerrit Glas also examined personal identity using Ricoeur's distinction between idem or sameness identity, and ipse, or selfhood identity, and showing that idem rather than ipse identity is affected by psychopharmacology.

Using the film 'Requiem for a Dream' together with another literary work, Wurtzel's *More, Now, Again,* Alison Mitchell attempted to identify a sense of self distinctive to and, in her analysis, resultant from drug addiction: a self as materialistic, passive and fleeting. Some of the ethical concerns arising from the use of forced psychotropic treatments to change identities for the criminal law purposes of readying a defendant to stand trial and a prisoner for execution were introduced by Jennifer Radden, Ph.D. and Al Freedman, MD.

Two discussions provided a welcome historical context for today's psychopharmacological practices. Vincent Gerard and Jean Naudin brought us back to the long relationship humans have had with mind changing substances. Louis Charland, Ph.D. reminded us of "moral treatment" in nineteenth century psychiatry, putting forward the argument that one cluster of the DSM-IV personality disorders, including hysterical, antisocial, narcissistic and borderline, invite not pharmacological but moral treatment aimed at a change of moral character.

Neil Scheurich M.D. mapped the professional division of labor wherein the psychiatrist medicates while a non-psychiatrist practices psychotherapy, insisting that in each and every act of prescribing, the psychiatrist too must "weigh what it means to have a self and to conduct a meaningful life."

A group of papers dealt with antidepressants. Even handedly and carefully, Jennifer Hansen, Ph.D. laid out the debate over medication for depression, contrasting the position of the psychopharmacological hedonists with that of the psychopharmacological Calvinists. Her conclusion: the use of psychopharmacology with depression must be evaluated within a larger, societal context. Russell Downham, Ph.D.'s paper was concerned with medicating away depression inasmuch as he uncovered the normative structure of the decision to reduce suffering, arguing that suffering has a particular value and epistemic function. Deprived of suffering we would be, as he puts it, without a reliable indicator of our true narrative commitments. In a related discussion, Charles Henry, MD., explored the way medications can diminish feelings of distress. Particularly the feeling of anguish, he argued, is so central to the experience of consciousness that only medications taken in bad faith will serve to eliminate it. But then, the "responsibility of human self creation" is lost.

Rather than focusing on depression, Nassir Ghaemi, MD raised some troubling ethical issues around treating mild mania, his goal to emphasize that the treatment of mania raises philosophical and ethical problems of its own, quite as important and importantly analogous to those raised by the treatment of depression.

Finally, Douglas Heinrichs MD in-

vited us to think more biologically. He used chaos theory to interpret models in neuroscience which emphasize shifting patterns of synchronized firing across widely distributed regions of the brain, concluding that since even slight differences in initial conditions will have wide-ranging effects, the effects of antidepressant drugs on the patient's self will be unpredictable.

Jennifer Radden, D. Phil.

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Review/Essay

From Detached Concern to Empathy: Humanizing Medical Practice, by Jodi Halpern. New York: Oxford University Press, 2001.

An article in the *Clinical Psychiatry News* described a recent unpublished study demonstrating that undergraduates planning careers in medicine are "significantly less empathetic than those planning careers in nonmedical mental health or education" (1). Furthermore, the study showed that medical training itself exacerbates rather than corrects that deficit. I had two reactions to this news. The first was "what are they calling 'empathy'"; the other, "what are we supposed to do about it?"

In *From Detached Concern to Empathy: Humanizing Medical Practice* (2), Jodi Halpern answers both of these questions. Drawing on her experience as a psychiatrist and trained philosopher, she takes on the ambitious and provocative project of demonstrating not only that emotions *do* play a role in ostensibly "objective" clinical decision making, but that they *should*. What is more, Halpern argues that the lack of empathy in clinical, especially hospital-based, care is the result of oversimplified conceptions of what empathy is, misunderstandings about the role of emotions with respect to empathy, and a medical pedagogy that teaches medical trainees to reason badly about matters emotional and evaluative. In short, she takes on assumptions underlying standard practices in clinical work and medical education, philosophical and psychiatric theories about knowledge and value, and a tradition within medical ethics and health law that protects at all costs an oversimplified notion of patient autonomy.

Halpern's notable success in this project clearly results from her breadth of knowledge. Her bibliography alone is remarkable, drawing from a wide variety of sources. In philosophy of mind, she draws from sources ancient to contemporary, analytic to continental; and from rationalist theories to the contemporary neuroscientific theories that empirically test them. In value theory, she draws from aesthetics to ethical theory, moral psychology, and recent work in medical ethics; and in psychiatry and psychology, she draws from classic readings from various schools as well as their more recent modifications. Throughout this wide-ranging discussion Halpern maintains a personal voice, as well as rigorous clarity in the development of her own ideas and the relationships between the smorgasbords of academic traditions that inform them.

Halpern's argument centers around the case study of "Ms. G", a patient for whom she was asked to provide a psychiatric consultation during her residency. Chapter 1 describes Ms. G's case as Halpern, the psychiatry service, the surgical service caring for Ms. G at the time of the consult, Ms. G's private internist, and the hospital ethics committee construed it at the time. Halpern uses this case to organize the questions addressed in the rest of the book. What do medical practice and training require of us as persons? What is the role of emotion in the objective world of medicine? As physicians, can we really eliminate the personal and societal values that guide our intuitive reactions in morally complicated situations? Of what medical value is clinical evidence provided by affects versus cognitions? In short, how far should we go in the name of good medical practice to include the subjective, the unquantifiable, and the personal in clinical decision making, and on what bases can the answer to this question be defended? Halpern approaches these complicated questions by challenging her own involvement and thought processes in Ms. G's care, systematically rethinking what she did at the time and why, and how we can prevent such mistakes in the future.

Chapter 2 argues that clinical reasoning should include emotional considerations as well as rational ones. Emotions play an unavoidable, necessary, and important role in clinical decision making, despite a long tradition of trying to exclude them. The discussion examines the "detached reasoning" that guides physicians' attitudes toward patients, and that is taught both implicitly and explicitly in the process of medical training. Whereas medical students and residents typically learn that we should not become emotionally involved with our patients, Chapter 2 argues that this tradition does not hold

AAPP Annual Meeting 2004 *Truth and Reconciliation*

May 1 & 2, 2004
New York, New York, USA
(in conjunction with the American Psychiatric Association Annual Meeting)

The Annual Meeting of the Association for the Advancement of Philosophy and Psychiatry will take place in conjunction with the Annual Meeting of the American Psychiatric Association on May 1 & 2, 2004 in New York City. This meeting will be devoted to the theme: Truth and Reconciliation. This year's conference focuses on intersections between health and mechanisms for reconciliation and healing from conflict and past wrongs.

In addition to presentations of submitted papers, there will be two keynote speakers:

(Saturday, May 1, 11:45 AM)
Mary Rawlinson, Ph.D.
Department of Philosophy
University of New York at Stony Brook

(Sunday, May 2, 10:30 AM)
Sharon Lamb, Ph.D.
Department of Psychology
Saint Michael's College

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across time and place. Rather, the ideal of emotion-free clinical objectivity is a relatively recent turn that stands in contrast to older medical traditions that view medicine as requiring rather than excluding emotional involvement.

Halpern's argument is that relationships between caregivers and patients need not be seen as a binary choice between detached reasoning and overinvolved emotional involvement that clouds medical judgment. The notion of medical objectivity comes from medicine's deliberate adoption of the Oslerian tradition of making medicine more scientific, in the sense that physicians can distance themselves from the emotional reactions that might cloud their clinical judgment. The physicians should neither ignore patients' emotions, nor engage with them on a personal level, but rather should observe them dispassionately in order to preserve her proper "equanimity."

Chapter 2 argues that in contrast to the Oslerian view, detached clinical observation of patients' emotions does not allow full understanding, in the manner that clinical observations of pathophysiologic states might. Emotional involvement on the part of the doctor is inevitable. Pretending that emotions do not influence clinicians' judgments leads us to make errors that might be avoided if we recognized our own emotional states. Furthermore, there is valuable clinical knowledge to be gained by engaging with patients' emotional states, and preserving a standard of artificial detachment sacrifices information that could be central to a patient's care. While Halpern recognizes that physicians' emotions do sometimes interfere with clinical judgment, her point is that medicine should strive to use emotional reasoning *well* rather than ignoring it altogether. In contrast to the Kantian tradition in which she locates the distinction, emotions and cognitions are not mutually exclusive. Subjectivity does not necessarily constrain objectivity. Emotional reasoning is both unavoidable and valuable and, Halpern argues, central to the concept of empathy.

Chapter Three develops the notion of "emotional reasoning" by elaborating Halpern's noncognitivist view of emotions. Chapter 3 refutes four common views of how emotions might interfere with clinical judgment in order to demonstrate how emotional reasoning differs from, and interacts with, detached reasoning. Halpern addresses the notions of "associational linking" (taken from psychology and psychiatry), "gut feelings," "emotional inertia," and the influence of moods and temperament on reasoning to show that (i) emotions are not necessarily detrimental to reason, but rather that (ii) "by cultivating greater emotional flexibility physicians can develop a fuller understanding of reality" (p. 57). Emotional influences such as "resonance" and "intuition" can contribute to and enrich clinical understanding. It is *because* rather than in spite of the fact that physicians' emotional prejudices can hinder clinical reasoning, and our moods and temperaments can influence our clinical perceptions, that Halpern sees emotional reasoning as a resource. If emotional reasoning can be developed as a skill, then we can avoid these errors (which we make whether we acknowledge emotional reasoning or not) while having richer understanding of our patients and their experiences of illness.

Chapter Four provides the heart of Halpern's positive argument. It defends a notion of clinical empathy as cultivated emotional reasoning, where 'cultivated' refers to the skillful use of subjective, emotional processes to learn more about patients that can be done with traditional information-collecting methods taught in medical training. Chapter 4 rejects conceptions of empathy as either a purely cognitive process or as the use of untrained, emotional, 'gut reactions'. First Halpern rejects the "detachment view" of empathy as inferences from what the physician can "objectively" observe about a patient's emotional states, because it cannot account for the richer, interactive meanings (emotional reasoning) that doctor-patient relationships–as any human relationships–provide.

In a creative, argumentative move, Halpern turns to aesthetics to develop empathy as "experiential knowing." Empathy is not something one stands apart from and reasons about without feeling; rather, having empathy is more like a visceral reaction to art, which is immediate and emotional. Empathy, like art, is not something one reasons about, but something one experiences directly. However, Halpern recognizes the limitations of this analogy: aesthetic appreciation of art is not nearly as complicated as understanding another person. She turns to Heidegger to broaden the notion of experiential knowing to a social context, by making some degree of commonality of interests, moods, and human struggles a precondition of understanding in general. Following Heidegger, Halpern argues that "what makes it possible to *understand* something is the prior possibility of being in relation to that thing, where *being* means existing–including the full range of affective and volitional activities" (p. 76). In other words, experiential knowing presupposes social meanings that cannot be accounted for by detached inferential understanding of another person's emotions.

Even experiential knowing has its limits for Halpern. She goes on to restrict the concept of experiential knowing by rejecting the Kohutian psychoanalytic view of empathy as emotional "merging," on the grounds that empathy does not consist in losing the distinction between self and other, so much as imagining what it would be like to be in the other's place. The self/other distinction does work for Halpern's view, because her notion of clinical empathy requires recognizing that the patient is not oneself. Empathy requires "decentering," detaching ourselves not from our own emotions completely, but from our idiosyncratic emotional standpoints. Decentering corrects for the physician's personal emotional reactions to a patient's experience. It is not a matter of "merging" with the patient, but of actively trying to imagine what that person's experience is like for him.

Clinical empathy thus maintains a cognitive as well as an emotional component to provide experiential knowledge of another person's emotional states. The cognitive component can be fulfilled through affective associations, or what Halpern calls emotional "resonance," as well as by simply asking a patient about his emotional world. The emotional component of empathy is provided by being attentive to affect, and by "skilled imagining" of how it feels to have the patient's experience. Far from being detached, the physician is an active participant in the emotional interaction. Full clinical knowledge, Halpern concludes, requires this sort of *comprehensive* rather than merely *accurate* appreciation of a patient's problems.

The positive argument of the book ends with Chapter 4. The remaining two chapters address the implications of this view of empathy for two central aspects of medicine: the ethical conception of autonomy, and the role of medical education in cultivating the skills of emotional reasoning that empathy requires.

Chapter 5 uses this conception of empathy as emotional, interpersonal, experiential knowing to challenge the traditional view of autonomy promulgated in medical ethics. To test the utility and limitations of her view of empathy, Halpern returns to the case study of Ms. G, and challenges her own moral and clinical reasoning at the time she did her consultation. This move has two effects: it reminds the reader that empathy is inherently a *practical* rather than an academic concept; and it makes its application *immediately relevant* to that reader as a moral agent herself.

The principle of autonomy is usually

defined as *laissez-faire* self-determination–a "legalistic" excuse not to interfere with a patient's free choice of medical treatment. Halpern sees this view of autonomy as following from the detached reasoning model of interactions between patients and physicians. The empathy model, Halpern argues, challenges this traditional view of patient autonomy as the ability to make one's own treatment decisions, whether they serve one's overall interests or not. Halpern finds that the empathy model provides richer notions of both agency and autonomy. As with knowledge, Halpern finds rational agency itself to be socially situated. The Kantian moral tradition, especially the third formulation of the Categorical Imperative, holds that agency requires full participation in a moral community of rational moral decision-makers. True freedom to act - i.e., agency itself- requires interpersonal engagement rather than detachment; it requires that we share one another's ends or goals.

Halpern finds this Kantian view too strong. In parallel to her argument against the Kohutian view of empathy as affective merging, she argues (with philosopher Barbara Herman) that we don't share *ends* so much as we share the deliberative *process* by which agents pursue their own ends. Without respect for the shared, communal process that forms the precondition for how autonomous agents can act, agents are not really free, and their decisions are not autonomous. Halpern thus demonstrates not only that the hospital staff's reasoning about Ms. G's autonomy was misguided, but that their actions with respect to her were morally wrong.

Chapter Six addresses the difficult question of how empathy-as-skillful-emotional-reasoning can be addressed in medical education. If the study I cited at the beginning of this discussion establishing empathy deficits in medical students (and thus residents and physicians) is at all correct, Halpern's solution to the "how to cultivate clinical empathy" problem will be critical for the influence her view of humanistic medicine can have. Emotional engagement of the sort she describes is something that must be learned and practiced as part of medical training. Doctors must not only seek out, but also be able to tolerate the strong and often unpleasant emotions of their patients. Our current *un*willingness to share the affective lives of patients, as made apparent in appeals to detached reasoning and medical "objectivity," will be difficult to overcome, and the teaching of the skills of empathy to medical trainees is made that much more difficult by the lack of physicians who currently have these skills.

The biggest problem for this project is the methodologic problem facing all interdisciplinary work. Disciplines give us rules of evidence and rules for argument; without them, the theories a writer uses to endorse her particular views can appear *ad hoc*. From a philosopher's perspective, this book's quick treatment of questions of mind and brain (knowledge of other minds and psychological solipsism, duality of emotion and reason, duality of objectivity and subjectivity), definitions of agency, the epistemological value of intuition, and what it means ethically to require empathy, might all be challenged for lack of philosophical rigor. Medicine could make similar criticisms about her survey of various psychiatric theories, and about the impracticality of imposing increased costs of caring on our temporally, financially, and emotionally depleted medical work force. Halpern recognizes that her view of empathy introduces increased obligations of self on the part of physicians, and that these may generate resistance to her model within the current health care system.

However, the challenge of good interdisciplinary work is to call into question the very assumptions that ground the perspectives of established disciplines, and this Halpern does admirably. In stark contrast to Cory Wright's commentary in the last issue of this newsletter, Halpern demonstrates how interdisciplinary work in psychiatry and philosophy need not be conceived as "miscegenation" of disparate fields (3), but as an exercise in justifying disciplinary boundaries and the unquestioned assumptions that ground them. Her project is to demonstrate that none of the intellectual traditions of philosophy, psychiatry, psychology, medical ethics, or medical education sufficiently addresses the simultaneously moral and epistemological question, "How should doctors care for patients?", with added emphasis on what it means *to care*. Her answer weaves together unique insights from her experience as a psychiatrist and a philosopher to articulate and challenge the unspoken assumptions of multiple disciplines. In medicine and medical education, this means challenging the silent premise, "Above all, feel no connection." In philosophy, this means making the epistemological and ethical claim not only that we *can* know other minds, but that we *should*. In medical ethics, this means remaining cautious that we not sacrifice to ostensibly principled algorithms our professional virtues and overall capacity for moral reasoning.

References

(1) Finn, R. "Empathy Deficit in Physicians Starts in Undergraduate Years." *Clinical Psychiatry News*, June 2003, p. 55.

(2) Halpern, J. *From Detached Concern to Empathy: Humanizing Medical Practice*. New York: Oxford University Press, 2001.

(3) Wright, C. "Commentary: On disciplinary miscegenation." *AAPP Bulletin* 10(2), 2002, 9-10.

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New York

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VIIIth International Conference on Philosophy, Psychiatry, and Psychology

Time, Memory, and History

September 23-26, 2004
Heidelberg, Germany

The 8th International Conference on Philosophy, Psychiatry, and Psychology will be held on September, 23-26, 2004 at the University of Heidelberg, Universitätsplatz, Heidelberg, Germany. The theme of the conference will be "Time, Memory, and History." It is meant to combine, among others, philosophical concepts of time and temporality, clinical and neurobiological approaches to memory and its disorders, and the historical dimension of mental illness as well as of psychiatry as a discipline. There will be a full schedule of plenary sessions, parallel sessions, poster sessions, and workshops on special training issues. Participants are invited to organize symposia concerning either the main topics of the congress or any other topic.

The organizing committee are T. Fuchs (Chairman), M. Bürgy, and M. Schönknecht. Abstracts for papers and symposia are due by April 30, 2004 and should be sent to Thomas Fuchs, M.D., Ph.D. at ppp.2004@med.uni-heidelberg.de. The conference Web site is http://psychiatrie.uni-hd.de.

The Neurohermeneutic Forum

Rumblings of dissatisfaction have surfaced repeatedly since the introduction of DSM IV. With the coming of DSM V, criticisms of psychiatry's current diagnostic nosology will hopefully evolve into concrete, specific proposals for constructive change that can be operationalized.

Complaints about DSM IV have been varied. Many opponents have attacked DSM IV's claim to data-driven "atheoreticity" by pointing out that empiricism is itself a distinct theoretical orientation. Some have opined that DSM IV's digitalization of diagnoses cannot accomodate the broad continuum of human behavior. Others have expressed annoyance at DSM IV's unwieldy overabundance of diagnostic categories. Finally, the most thoroughgoing critics have questioned the necessity for an "intersubjectively reproducible" clinical classification scheme of any kind: they argue that DSM should retreat completely from the world of patient care and revert to its originally restricted purpose of standardizing only research studies.

Such complaints imply solutions, each of which one can imagine as a potential alternative launching platform for DSM V, VI, or VII. The problem of an implicit epistemological bias within DSM IV suggests that any revised nosology might make its theoretical orientation explicit and pluralistic in order to encourage openness and balance. The limitations of DSM IV's digital character raise the intriguing possibility of continuously dimensionalized criteria underpinning the next taxonomy. Overelaboration of categories in DSM IV argues for rigorous economy in future diagnostic parsing. And a poor fit between DSM IV's intersubjective standardization and the individuality of each patient brings up the question of building a narrative structure into DSM revisions down the road.

All of these ideas have partial merit, but none addresses the fundamental flaw in DSM IV: current psychiatric diagnosis is predicated on an outmoded and false equation of conceptual structure in science with mere taxonomy. If psychiatry is to become truly scientific in the twenty first century, normative psychology must transcend pure nosologic categorization as all mature sciences have done. Ad hoc classification must give way to invariant laws.

The quintessentially mature science of our time is physics. In the 1800s, premodern physicists began to order a bewildering array of chemical elements and compounds into an ad hoc classification scheme known as the periodic table. In the 1900s, subatomic particles joined elemental atoms and compound molecules as candidates for a more overarching taxonomic framework. The intellectual breakthrough that systematically pulled together all these entities was the algebra of law-like invariances.

Mid-twentieth century physicists discovered that sets of "quantum numbers" assigned to distinct energy states of particle systems are sometimes redundantly "degenerate"; that is, more than one set of quantum number values apply to a relevant energy state. The energy equivalence of such differing quantum number sets allowed them to be arranged diagrammatically in "multiples" whose patterns revealed invariant laws governing the germane physics. Rigorous algebras of highly specific "groups" could be used to characterize the invariances. Once those algebraic laws were in place, ad hoc classification schemes like the periodic table became superfluous; the succinct laws themselves replaced messy particle taxonomies and expanded the explanatory and predictive potency of physicists accordingly.

Defenders of DSM IV might argue against analogies between behavioral norms and the laws of physics by citing scale-dependent structural differences between particle groupings and biological taxonomies. It is certainly true that living things, although they are physical systems, demonstrate emergent properties beyond those of their particulate microconstituents. It is also true that psychological phenomena are more accurately identified through biologically emergent properties than through elemental physical substrates. Yet biologists even now are starting to make taxonomies of life yield to the law-like logic of algebraic invariance, albeit at a quasi-molar emergent level.

When Linnaeus assembled his nosology of species, genera, phyla and the like several hundred years ago, he was cobbling together a hodge-podge of different criteria without any formal mathematical interrelationship. When Darwin conceived the theory of natural selection in the nineteenth century, his understanding of variation and extinction as random processes provided no structure to systematize the scaffolding on which Linnaean classification hung. When Watson and Crick elucidated the molecular character of the gene in the early 1950s, their chemical decryption initially revealed no energetic stabilities configuring possible law-like patterns in evolution. But now it has been shown that patterns and stabilities of a kind exist. Reduplication of "homeotic" DNA segments within individual genomes form repetitive nucleotide sequences whose differentiation leads to an emergent phenotypical "periodic table" of sorts. Moreover, some homeotic gene segments manifest behavioral functions. Hence, biological emergence no longer presents a theoretical barrier between the group-algebraic methodology of particle physics and the nosology of human behavior.

Psychiatry does not have to descend into physical reductionism or genetic determinism to exploit the analytic power of algebraic invariance. Psychological emergence may well turn out to mandate a profound difference between the specific law-like algebras useful to future psychiatrists and invariant properties governing particle physics or, for that matter, homeosis. Even among concepts of invariance now employed by physicists, different phenomenological domains require different law-like structures. Some are hidden, discrete, complex, or globally standardized like the tenets of DSM IV. Others are explicit, continuous, simple or locally variable like some proposed post-DSM IV architectures. Only a rigorous mathematical exploration of normative psychological phenomena, employing a range of possible group algebras, will sort out the actual laws that can make psychiatric nosology consistent with mature science. Such an exploration should be the process by which future versions of DSM are born.

Donald Mender, M.D.

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Review/Essay

Naturalizing Phenomenology: Issues in Contemporary Phenomenology and Cognitive Science, edited by Jean Petitot, Francisco J. Varela, Bernard Pachoud & Jean Michel Roy. Stanford: Stanford University Press, 1999.

Contemporary psychiatry straddles a gap between the talking cure and psychopharmacology, between the interpretation of symptoms and symbols and seeking the causes and cure of psychopathology at the level of synapses and neural nets. Clinical practice typically finds room for both *Listening With The Third Ear* and *Listening To Prozac*. It was ever thus. Freud reluctantly abandoned neurophysiology for the interpretation of

dreams, yet struggled to reconcile his hermeneutic reflections with the naturalistic, "scientific" ideal of explanation by couching his metapsychological theory in metaphors drawn from biology and thermodynamics.

But psychiatry is not alone in this predicament. Ever since Descartes, philosophers have struggled with the problem of bridging the gap between mind and matter, or between the characteristics of experience and thought as subjective phenomena and the world disclosed to a science that seeks to be rigorously objective.

Cognitive Science promised to close this gap by drawing upon artificial intelligence, a computational theory of mind, and exciting advances in neurophysiology and linguistics. If machines can carry out intelligent functions as well, or even better than human beings–and can do so by employing material resources far less intricate than the human brain, surely the gulf between mind and matter had finally been bridged, opening the way to naturalistic theories of mind and cognition. But that promise soon proved deceptive. For the bridge never reached the *phenomena* it promised to explain. Critical philosophers pointed out that although machines may display colors and images, the machine itself cannot see the colors it displays, that although computers can win or lose at chess, no computer ever experiences what it is like to win or lose–or even to experience computation. Nor does computer simulation of intelligent functions entitle us to conclude that our own intelligent functions computationally.

Naturalizing Phenomenology sets out by charting this gulf between scientific theories of mind and the phenomena they seek to explain. The book is the product of the activities of the Phénoménologie et Cognition Research Group, which held a series of seminars in Paris and a conference in Bordeaux on "Actualité cognitive de la phénoménologie: Les défis de la naturalisation." In their long introductory essay, "Beyond the Gap" volume editors Roy, Petitot, Pachoud and Varela set the stage for all the essays that follow by focusing first on the recognition that Cognitive Science suffers from an "explanatory gap" between its attempts to provide naturalistic, physicalistic or materialistic accounts of the mind and the phenomenal or qualitative experience of mental states processes as they are experienced *by* the mind. The authors provide a lucid account of how this problem has arisen in cognitive science, where it is usually rather vaguely described as the problem of accounting for "qualia" or as "the hard problem" of explaining consciousness. The editor-authors urge that the problem of the explanatory gap cannot be clearly and properly posed without resorting to the more precise and rigorous analysis of conscious experience to be found in Husserlian phenomenology. Lacking that, one side of the "gap" remains far too indefinite to allow for any fertile research. But most cognitive scientists have ignored or even shunned phenomenology. Dan Dennett mischievously treats phenomenology as a primitive religion. He proposes to eschew any appeal to first-person, direct experience as too subjective to meet the demands of scientific objectivity and to substitute an interpretation of the statements and actions of others that he dubs "heterophenomenology." Of course, this will seem an oxymoron to anyone schooled in the tradition of Husserlian phenomenology.

On the other hand, "naturalizing phenomenology" would have seemed an oxymoron to Husserl. For, as Roy, Petitot, Pachoud and Varela remind us, "Husserl's phenomenology is not only non-naturalist, but anti-naturalist....in the sense that its own fundamental theses stand in direct opposition to those of philosophical naturalism." They locate this anti-naturalism against the background of a remarkably clear and concise introductory survey of Husserlian phenomenology. They find that Husserl's objections to naturalism centered in his conviction that natural science depends upon a mathematization of the field of inquiry that he saw as radically incompatible with the "inexact and vague morphological essences involved in what we experience immediately." But, they argue, Husserl's objections have been rendered obsolete by two "scientific revolutions," "namely, the emergence of a theory of computational processes as well as a theory of the self-organization of complex systems." They propose that these recent developments now promote "the collapse of the opposition between body and mind" and that new developments in the mathematics of non-linear dynamic systems open the possibility of a mathematization of lived phenomena so that phenomenological data can be adequately reconstructed on the basis of the main tenants of cognitive science and then integrated into the natural sciences." If that entails some modification of classical phenomenology, they point out that Husserl himself opened avenues of reflection on embodiment that breached his objections to naturalization and that successors such as Merleau-Ponty, who further developed those themes, have prepared the way for a phenomenology that can complement these scientific developments so as to bridge the gap between mathematical physics and qualitative experience.

The authors do not pretend to provide such a bridge. Their essay undertakes to survey the prospects of naturalization and analyze the obstacles so as to establish a context for the following twenty essays, which fall into three parts: *Intentionality, Movement and Temporality, Mathematics in Phenomenology* and *The Nature and Limits of Naturalization*. The international assemblage of contributors ranges from neurobiologist Varela to cognitive scientist Tim Van Gelder to Husserl scholars like Dagfinn Follesdal. None of the essays deals directly with psychopathology or clinical issues, though several tackle questions of obvious relevance. But because the collection seeks to redefine the horizons of the study of the mind in a way that respects both subjective experience and the demands of natural science, they should prove provocative to all philosophers, psychiatrists and psychologists who struggle to unite the two in theory and in therapy.

Melvin Woody, Ph.D.

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AAPP in the APA

(Wednesday, May 5, 2-5 PM)

AAPP Sponsored Symposium
"Dissociative Disorders: Issues of Culture and Issue of Trust"
(Deborah Spitz, Chair; Christa Kruger, Nancy Potter, Vedat Sar)

(Saturday, May 1, 9 AM-4 PM)

Course
"The Conceptual Basis of Psychiatry"
(S. Nassir Ghaemi, David H. Brendel)

(Thursday, May 6, 2-5 PM)

Symposium
"Institutional Ethics in Psychiatry: A Multidisciplinary Perspective"

(David Brendel, Chair, Alan Stone, Discussant; Alexander Bodkin, Rebecca Brendel, Scott Lucas, Jennifer Radden)

Psychiatry and the Media

Public Feelings About the Mentally Ill

In 1946, *Life* magazine ran a report by Albert Q. Maisel entitled "Bedlam 1946" on the terrible conditions in state mental hospitals, and in 1948, Albert Deutsch published his influential *Shame of the States*, also calling for the reform of mental hospitals. Mary Jane Ward published her novel *The Snake Pit* in 1946, which was made into a popular movie starring Olivia de Haviland, about a woman who is sent to a mental ward that resembles a human snake pit. In 1953, Kenneth Appel, head of the American Psychiatric Association, condemned the state of state mental hospitals in his presidential address. These and other events led to a heightened public awareness of the problems in the treatment of the mentally ill, and led politicians to take action to improve matters.

In the last couple years, the *New York Times* has run a number of articles by Clifford Levy revealing horrendous treatment of people with severe mentally illnesses in state-licensed, privately run homes. Levy's reporting clearly showed that the New York State authorities had failed in their duty to ensure minimum levels of care. The abuses and profiteering in the nursing homes scandal not only caused needless suffering but may also have led to the deaths of patients. There has been little coverage of these news items by other local newspapers or television stations, which has led many to wonder whether news editors do not think they are newsworthy or whether they are under some pressure to keep these stories out of the headlines. It was predictable yet still disappointing that these scandals apparently caused no problems for the re-election of Governor George Pataki in November, 2002.

In the last decade or so, other newspapers have also occasionally reported on the grave problems in the treatment of the mentally ill, and there have been a few books highlighting the same issues. Jay Neugeboren's *Imagining Robert* (William Morrow, 1997), Rael Jean Isaac & Virginia C. Armat's *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill* (Free Press, 1990), and E. Fuller Torrey's *Out of the Shadows: Confronting America's Mental Illness Crisis* (Wiley, 1996) are notable examples. But these books and articles seem to have little effect on the public awareness of the plight of the mentally ill. Instead, we get more news stories about the dangerousness of the mentally ill and politicians proposing regulations limiting the freedom of people with mental illnesses.

In October, I attended the Tenth Annual Mental Illness Awareness Day Conference, organized by the Clubhouse of Suffolk on Long Island, New York, a private, non-profit psychiatric rehabilitation and support agency. The main speakers were Lauren Slater, author of several books including the personal memoir *Prozac Diary*, and Kay Redfield Jamison, Professor of Psychiatry at the Johns Hopkins University School of Medicine, a 2001 recipient of a McArthur Fellowship, and best known as author of *An Unquiet Mind* and *Night Falls Fast: Understanding Suicide*. Both speakers gave excellent presentations, and both addressed the question of whether mental health professionals with mental illnesses should treat patients. Slater argued the field of psychotherapy needs to welcome wounded healers because although there are dangers in people with mental disorders treating patients, there is also a great potential benefit, with a strong connection between therapist and client. Jamison explained that once she published her memoir telling of her own manic depression, she decided with regret she should no longer see patients; yet she still meets and offers advice to professionals who themselves have mental illnesses but are wary of being open about their status with peers or patients. Psychiatrists and psychologists who disclose their own mental illnesses risk their very careers. The issue is not really about the question of whether "wounded healers" can do their jobs well; such professionals may need to take special steps to ensure that their disorders do not interfere with their professional judgment about what is best for their patients, but they should be able to carry out their duties as well as any other professional. Unless one is to propose that nobody with a history of serious mental disorder should ever hold a job involving responsibility for the welfare of other people, there should be no serious question about the ethics of mental health professionals with such histories keeping their jobs, even if there may be grounds for closer supervision of the work of these professionals.

The issue that links these two cases is that of the stigma facing the mentally ill. It seems that despite the move towards a more biological psychiatry in the last fifty years, the general public is still reluctant to face the issue of mental illness squarely and take a humane attitude toward people with mental illness. The scandals about state mental hospitals in the late 1940s led to changes in policy, but the resulting deinstitutionalization of the mentally ill was hardly a great success, given the lack of follow-through in creating alternative forms of community care. The public at the time was shocked and changes in policy were made, but the fundamental problem was not satisfactorily addressed. The public reaction (or the lack of it) to the nursing homes scandals of 2002 in New York suggest, and the reluctance of the mental health profession to address how to make room within it for those with mental illness both point to an unhappy conclusion. The old stigma surrounding mental illness is still strong and serves to prevent our society from doing all it can to provide those who need support with the help they need.

Christian Perring, Ph.D.

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(Editor's Column, continued from page 1)

be found in the work of his disciple? I will try to address these questions.

What strikes one immediately on reading the protocols of the seminars with the Zurick psychiatrists is that Heidegger is engaging them in the basic concepts of his philosophy, offering them, as it were, a course in *Being and Time* 101. In writing his chapter on Heidegger in *The Phenomenological Movement*, Herbert Speigelberg questioned thirty years ago how much interest Heidegger retained in phenomenology as such after the publication of *Being and Time*. Here in the *Zollikon Seminars*, however, we find Heidegger in the final decades of his life actively teaching the version of phenomenology he pursued in *Being and Time*. There is little question that he considered the distinctions and descriptions of that early work of enduring relevance. In one of his frequent cautions against the calculative thinking that predominates in contemporary science, he writes typically in the *Zollikon Seminars*: "Thinking in terms of calculability must be abandoned. Otherwise one cannot see the phenomena" (p. 202).

There is a reason, of course, for Heidegger's focus on the categories of *Being and Time*, as opposed to a focus on the thinking of being that we find in most of the later writing. It is a question of audience. In these seminars the audience is not a group of philosophers who have a longstanding familiarity with the course

of Heidegger's thought. They are rather practicing psychiatrists and psychiatrists in training who are thoroughly embued with a scientifically based psychiatry. Heidegger is relentless in his effort to challenge the philosophic assumptions on which these clinicians base their work. He carries out this task, as we might expect, in the distinction from *Being and Time* between human reality (*Dasein*) and non-human beings–and in the distinction between worldly things in their originary, meaning-filled relation to man (*Zuhandenheit*, or ready-at-handness in *Being and Time*), and things as objectified by the scientific outlook (*Vorhandenheit*, or present-at-handness in *Being and Time*). The epochal mistake of a scientifically based psychiatry is to treat humans (and their psychiatric disorders) as objects of scientific investigation rather than as the Beings-in-the-World that they are. "The unavoidable result of such a science of the human being would be the technical construction of the human being as machine" (p. 135). Not surprising, the psychiatrists apparently have a lot of difficulty relinquishing their customary way of seeing things in favor of Heidegger's alien approach. Boss remarks in his introduction:

> Some of the seminars were recorded in a way that must make it obvious to the reader, from the written record, just how exceedingly difficult the seminars were at the beginning. This is clearly evidenced by the fact that the discussions and responses were separated by long silences and pauses and by the fact that these scientifically educated doctors had never encountered most of Heidegger's questions as questions. Many participants seemed to be shocked, even outraged, that such questions would be permitted in the first place. At the start of the seminars in the late 1950s, even I was able to assimilate Heidegger's thinking only as a beginner would. I could provide very little help in overcoming the pauses in the conversations. Quite often the situations in the seminars grew reminiscent of some imaginary scene: It was as if a man from Mars were visiting a group of earth-dwellers in an attempt to communicate with them (p. xviii).

In his effort to lead his psychiatrist/students into a new way of seeing things, Heidegger focuses on a number of basic issues, four of which I will review here. The first two, space and time, are directly related to the treatment of these themes in *Being and Time*. The third, the body and psychosomatic conditions, introduces a theme that is notoriously scanted in *Being and Time*. And finally, Heidegger address a number of concepts associated with psychoanalysis and psychodynamic psychotherapy.

To address the dimension of space Heidegger uses the example of the table around which the group are seated. "The table is in its own place and is not simultaneously there where Dr. R. is seated. The table there is present-at-hand [*vorhanden*], but as a human being Dr. R. is situated in his place on the sofa, and he is also simultaneously at the table. Otherwise, he could not even see the table at all. He is not only at his place and then also at the table, but he is always already situated there *and* there. He is ontologically *situated* in this space [the room]. We are all in this space. We reach out into the space by relating to this or that. In contrast, the table in *not* 'situated' in space" (p. 8). The point, according to Heidegger, is that a human being and a table do not occupy space in the same way and that it is a profound mistake to think of the spatiality of the human subject as one would of the spatiality of the table. "The table is in space in a different way than the human being" (p. 12). Further, the notion of space as a neutral, objective dimension in which we locate the table received its full, mathematical articulation with Galileo and Newton. The great mistake of modernity, from whose entrapment Heidegger wishes to free his students, has been the expectation of explaining man in the categories of natural science. "According to natural science, the human being can be identified only as something present-at-hand in nature. The question arises: Can human nature be found at all in this way? From the projection of the natural sciences, we can see the human being only as an entity of nature, that is, we claim to define the human being's being utilizing a method never designed to include its special nature" (p. 26).

Heidegger's treatment of the dimension of time is far more extensive and occupies a large amount of his seminar time. He makes a fundamental distinction between time as a series of now-points, a notion that was introduced by Aristotle and that has become formalized in the scientific treatment of time as a measurable succession, and time as a lived human process. Heidegger carefully traces four qualities of time as it is lived by human beings. First, time is *significant* in that it always time for something. Second, time is *datable*, not in the calendar sense but in a more fundamental way on which calendar time is based, a manner of human time extending back into the past and forward into the future. Third, time is *extended*. For example, the "now" of human time is not a single point on the clock but is stretched, for instance, into the "now" of a conversation or the "now" of my writing this review. Finally, time is *public*. For example, in a discussion of the French Revolution, we share a common, public sense of that time period. Heidegger argues for the priority of this features of time over the objective, now-point time of the scientist. "Then how about the question of priority? If you ask a physicist, he will tell you that the pure now-sequence is the authentic, true time. What we call datability and significance are regarded as subjective vagueness, if not sentimentalism" (p. 50).

Heidegger follows the discussion of time with an analysis of memory. He challenges the psychological notion of memory as a "container" of events that are not immediately present as another example of treating man as an object or thing. In analyzing human memory Heidegger makes a major distinction between memory as making-present (*Vergegenwärtigung*) and memory as retention (*Behaltung*). The seminar protocols indicate extended discussions with the psychiatrists over the example of remembering, or making-present, the Zurick train station. They are in some real sense *at* the train station, as opposed to simply sitting in Boss's house with an idea of the train station in their heads. The psychiatrists, as in all probability the reader of the book, have a lot of difficulty understanding that there is more than one way of "being-at" (*Sein-bei*), and that being physically present and remembering/making-present are both, albeit different, modes of "being-at." For Heidegger, of course, this is a dramatic example of doing phenomenology, of allowing the phenomenon of remembering to show itself, as opposed to accepting an arbitrary, e.g. natural-scientific, interpretation on the phenomenon.

In taking up the question of the body, Heidegger engages a topic to which he devoted minimum attention in *Being and Time*. Responding to a reminder of Sartre's reproach that he had written only six lines about the body in the whole of *Being and Time*, Heidegger responds, "I can only counter Sartre's reproach by stating that the bodily [*das Leibliche*] is the most difficult [to understand] and that I was unable to say more at that time" (p. 231). Heidegger does indeed have more to say in the *Seminars*.

In language we are familiar with through Merleau-Ponty, Heidegger distinguishes sharply between the body as an object of objective (or scientific) inspection (*Körper* in German) and the body as

lived (*Leib* in German). He cites numerous examples of the lived body as "bodying forth" into the world, as opposed to the objective body located in neutral space. Referring back to the example of the Zurich train station, he notes: "We said: We are not physically present [*körperhaft*] at the station while making-it-present. But [are we] perhaps [there] in a 'bodily' manner [*leibhaft*]" (p. 84).

Taking up emotions and their bodily expression, Heidegger questions: "How do we measure sadness? Evidently, one cannot measure it at all. Why not? If one approached sadness with a method of measuring, the very approach would preclude sadness as sadness beforehand. Here, even the claim to measure is already a violation of the phenomenon as a phenomenon" (p. 82). Heidegger, of course, did not enjoy access to the Hamilton Depression Scale; but he surely would have questioned, have we with the scale lost the phenomenon of depression?

Taking up the topic of pain, Heidegger questions: "When you have back pains, are they of a spacial nature? What kind of spaciality is peculiar to the pain spreading across you back? Can it be equated with the surface extension of material things?" (p. 84). He suggests that the scientifically naïve layman comes closer to the phenomenon of bodily pain than the scientifically trained doctor. In all of these examples Heidegger insists that, phenomenologically, we cannot resolve the mysteries of the lived body by arbitrarily separating the psyche and soma and treating the first with intuition or phenomenology and the second with objective scientific measurment.

Finally, it is in the area of psychoanalysis and psychoanalytic concepts that Heidegger's discussions touch most directly on clinical practice. He displays a clear animus against Freud for the latter's effort to understand the human being in the categories of natural science. Heidegger's most general critique–one we are familiar with both through philosophers like Wittgenstein and his followers as well as through philosophers such as Ricoeur writing in the hermeneuetic tradition–is Freud's attempt to explain human behavior through causal connections rather than through links of meaning and motive. "...according to Freud, only that which can be explained in terms of psychological, unbroken, causal connections between forces is actual and genuinely actual....A cause follows according to a rule. In contrast, nothing like this is required for determining a motive. The motive's characteristic is that it moves me and that it addresses the human being. There is obviously something in a motive that addresses me. There is an understanding, a being open for a specific context of significance in the world" (pp. 7 & 23).

Heidegger also rejects the unconscious, a signal concept of psychoanalytic thought. Responding to a question from Boss regarding a woman who leaves her purse behind in the room of a man in whom she is interested, and the psychoanalytic interpretation that her forgetting her purse represents an unconscious wish to return there, Heidegger responds with a nuanced, phenomenologically based interpretation. From Heidegger's phenomenolgical perspective, in departing, the woman, because of her attachment to the man, is still present. And further, "...while being in the room, she was with her friend so much that the purse was not there at all" p. 169). We then don't need to invoke an unconscious explanation for leaving the purse since, phenomenologically, the purse was not there and therefore not left behind.

We could certainly raise challenges to Heidegger's treatment of these issues. The cause/meaning controversy is an old battle in psychoanalysis that currently has many of psychoanalytic troops siding with Heidegger on the issue. The debate over a reified unconscious is also old fare; and what Heidegger omits in his critique is that the "unconscious"–in whatever manner it is articulated–reflects a sense of psychic conflict that is left out of the phenomenological account (e.g., that the woman may want *and* not want to be with the man, that she may be (phenomenologically) present *and* not present in the room after she has left).

Perhaps more interesting, and less controversial, than Heidegger's critiques of causality and the unconscious are his reinterpretations of other psychoanalytic notions such as introduction and projection. Of the former he offers a succinct phenomenological account. "By imitating the mother, the child orients himself *toward* his mother. He takes part in the mother's being-in-the-world. He can do this only insofar as he himself is a being-in-the-world. The child is absorbed in the mother's comportment. It is exactly the opposite of having-introjected the mother. Even [when the child is] 'out there,' he is still tied to the ways of another human being's being-in-the-world—his mother's" (p. 163).

With this brief review of Heidegger's treatment of space, time, the body, and psychoanalysis—which topics do cover much of the Zollikon seminars and related discussions with Boss, we may now ask how relevant and useful these analyses are for clinical psychiatrists–those in the Zollikon seminars and those reading the book today. The discussions of space and time are clearly valuable for another audience, sc students of Heidegger who profit from a further delineation of the analyses of these themes introduced in *Being and Time*. But what about practicing psychiatrists? It is indeed striking how little time in the *Seminars* is devoted to actual patients and clinical conditions. Heidegger acknowledges the psychiatrists' impatience in a letter to Boss: "I understand very well that your colleagues have become impatient and that they have the impression that I am taking a circuitous route by which they can encounter nothing tangible" (p. 271).

Opinions will certainly differ on this question, and I will conclude this review by offering my own. Heidegger's analyses of space, time, and the body offer nothing very concrete in the investigation of psychiatric disorders. On the other hand, he is clear that with his "circuitous route" he is attempting to address fundamental issues which are propaedeutic to any serious thinking about mental illness. In one of the seminars he states: "There is the highest need for doctors who *think* and who do not wish to leave the field entirely to scientific technicians" (p. 103). Heidegger's goal is clearly to train these doctors to "think," and for him that means to break the spell of the natural scientific method in their efforts to understand themselves and their patients. Now, given the utter dominance of the natural scientific model in contemporary psychiatry, a powerful challenge to that model as sufficient for an adequate understanding of the human being seems as necessary today as it was during the decade of the seminars. It is clearly arguable that Heidegger's is not the only alternative to the natural-scientific method, but it is equally arguable that his alternative is a powerful one.

We are still left with the question: where would Heidegger's analyses take us in psychiatry if we were able to think our way out of being "scientific technicians"? We have one answer in the work of Boss himself. It is very clear from the discussions and correspondence with Boss in this volume that the latter's magnum opus, *Existential Foundations of Medicine and Psychology* (New York: Aronson, 1979), was written under the direct guidance and approval of Heidegger. It is then fair to say that the application of Heideggerian philosophy to clinical practice that is *not* found in the *Zollikon Seminars* is in fact to be found in Boss's book. This presents a problem for someone like myself who likes the analyses of the *Zollikon Seminars* but has little enthusiasm for Boss's *Existential Foundations*. In the latter book Boss places an enormous em-

phasis on Heidegger's understanding of the human being (*Dasein*) as a clearing (*Lichtung*) of being, whose 'essence' is to disclose the world and one's own possibilities of existing. Boss interprets virtually all psychopathology as a failure of self-disclosure (not in the sense of not saying what is on one's mind but rather in the deeper, Heideggerian sense of not opening oneself to one's possibilities.) Heidegger adumbrates this approach himself in one of his conversations with Boss: "The human being is essentially in need of help because he is always in danger of losing himself and of not coming to grips with himself. This danger is connected with the human being's freedom. The entire question of the human being's capacity for being ill is connected with the imperfection of his unfolding essence. Each illness is a loss of freedom, a constriction of the possibility for living" p. 157). In the practice of psychiatry I find this approach both correct and therapeutically useless. It is both correct and useless because it is so general–it may be applied anywhere and to anyone; it offers me very little in understanding why this patient suffers from this particular condition at this time. (Personally, I find the analyses and case histories of Binswanger, whom Heidegger and Boss never tire of putting down for his misunderstanding of Heidegger, more interesting than Boss's analyses.)

The conclusion I draw from my disparate reactions to the *Zollikon Seminars* and Boss's *Existential Foundations* is that Boss and Heidegger made a major mistake in trying to derive a theory of psychopathology directly from Heidegger's philosophy. As flattering as this obviously was to Heidegger, he would in my opinion have done better with the more modest goal of the seminars: to help his psychiatrist/students appreciate the limitations of an understanding of human beings and psychiatric disorders based solely on the objectifications of the scientific model–and to let them take it from there.

Even discounting the problems attendant on a direct application of Heideggerian philosophy to psychiatry as with Boss, Heidegger's text presents a further problem for the contemporary psychiatrist. This problem is the obverse of the credit I just accorded Heidegger in drawing our attention to the limitations of a psychiatry grounded in the natural sciences. Heidegger's aversion to a natural-scientific interpretation of human being is in fact so extreme that he offers no assistance in the daunting challenge of making room for the natural sciences in a *Dasein*-oriented psychiatry. Dasein is brain as well as mind, and we face the challenge of integrating the two every time we prescribe an antidepressant. Heidegger even makes it clear, as indicated above, that it will not do to split the psyche and the soma and treat the one phenomenologically and the other scientifically. But he does not provide any way out–not even a hint–of this impasse. As much as we may credit him for a powerful critique of scientific reductionism, do we not have to question whether he is guilty of a phenomenological reductionism that leaves little place for a 'science' of psychiatry and little understanding of what happens, daseinsanalytically, when we prescribe that antidepressant. One gets the impression from the text that this issue troubled Heidegger's psychiatrist/students in the 1960s; how much more will it trouble contemporary psychiatrists who live with the exploding fields of neuroscience and psychopharmacology.

James Phillips, M.D.

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