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From the Editor

The Case for a Psychiatrically Informed Philosophy

"Men are so necessarily mad that not to be mad would amount to another form of madness." (*Les homes sont si nécessairement fous, que ce serait être fou par un autre tour de folie, de n'être pas fou.)* Blaise Pascal, *Pensées* #414.

Before explaining my invocation of Pascal, let me acknowledge that in framing my own commentary on Jennifer Hansen's target article, I have taken advantage of my position as editor to review the commentaries of my colleagues as they have come in. My remarks thus arise as much from those commentaries as from the target article itself.

So why Pascal? Because he captures something I have found oddly missing in the commentaries in this issue. Pascal engages us, interrogates us, in a deliberation on madness and sanity, on the madness that inheres in sanity, and on the suspect quality of too insistent a claim for sanity. Now I can already hear the chorus of my colleagues protesting, get real, we can tell the difference between a schizophrenic and a non-schizophrenic; enough of this romantic drivel. So let me explain further.

In organizing this symposium around the title, "Philosophy and Psychiatry: Reading and Writing from One Side of the Divide - or the Other," I had in mind two kinds of questions - what can philosophy do for psychiatry, and what can psychiatry do for philosophy - both to be addressed by individuals in either of the two disciplines. What I have found, however, is a tendency for both philosopher and psychiatry commentators to focus rather exclusively on the first question. Scott Waterman writes: "The list of questions that we psychiatrists face and with which we need serious help from philosophers is long." Tim Thornton writes: "Within the original debate about anti-psychiatry is a question of continuing interest that is continuous with psychiatric practice although it need not be taken directly to threaten the very possibility of such practice. It concerns how best to understand the central subject matter of psychiatry: the treatment of mental ill health. And the resources required for addressing it are conceptual, and thus philosophical, as much as they are empirical." And Jennifer Hansen herself writes: "Philosophers can play a useful role in clarifying conceptual confusions, demonstrate the weakness of some of the arguments made against psychiatry, and the flawed nature of the critics assumptions."

What these quotations and the commentaries suggest is that our shared interest is in the first question, what light philosophy can shed on the issues we face in psychiatry.

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From the Co-Editor of PPP

Nurturing the Interdiscipline

John Z. Sadler, M.D.
Co-editor, Philosophy, Psychiatry, & Psychology (PPP)

Last week I received an e-mail from a yeoman reviewer for the journal, an experienced clinician and expert in his sub-specialized field. He wrote to complain about the low quality of the last few PPP submissions, and thought this reflected poorly on the journal and field. He thought the editors should be more aggressive in screening out problematic submissions. He was considering stepping down as a reviewer.

I wrote back. I said I completely understood his perspective and frustration. Indeed, I (and Dr. Fulford) have sent out our share of seriously flawed papers. But I asked him to hear (read!) me out, to give some perspective. I said I'd hate to lose him as a reviewer.

When PPP was launched fifteen years ago, we all knew that the shape of the journal would require careful attention and extensive editorial input. After all, no one knew what the emerging interdiscipline of psychiatry and philosophy would, or should, look like; we had sketchy understandings of what "rigor" would be in the journal; and we didn't know what kind of compromises we would have to make in order to make the journal rigorous, profound, appealing, and relevant.

For this reason, we asked our reviewers in those early days to be not just peer critics, but also peer educators. We thought that the review process was an opportunity to shape the journal, its authors, and its readers into a vision that would make PPP rigorous, profound, appealing, and relevant. From those early days we sent papers out for review that were, well, in need of work. We saw the review process as a way of nurturing the interdiscipline, and as I have often said, "expanding the circle."

While the journal, the field, and we have come a long way, the review process for PPP remains the same, both a critical and educational enterprise. Bill and I still have a low threshold for sending a submission out for review. We are still looking for reviewer-educators willing to take up the challenge. The members of our field continue to learn from each other. I explained this to the reviewer, and he understood and agreed to stay on.

A couple of weeks before this e-mail incident, I had received another e-mail from a psychiatrist colleague, also a yeoman reviewer and contributor, complaining that the clinical perspective is being lost and that too many of the PPP papers are clinically naive. In this case, I believe the volume of editorial work has made it difficult for Bill and me to give all the papers the careful reading they deserve, and we should work harder to be

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Philosophy and Psychiatry: Reading and Writing from One Side of the Divide—Or the Other

This issue of the AAPP Bulletin is devoted to a symposium on the engagement of philosophical and psychiatric issues from the vantage points of the two disciplines. The engagement has been taking place since the late 1980s, when it started in a formal way both in the US and the UK. Local, national, and international groups, as well as PPP, the IPPP books series, the MIT and other book series, and of course this Bulletin, have been the meeting places for our exchanges. This symposium represents at attempt to step back and reflect on what we have been doing. The authors are philosophers, clinicians, and occasionally an author who is both. The format for the symposium is a target article by philosopher Jennifer Hansen, commentaries by a group of philosophers and clinicians, and a response to the commentators by Professor Hansen.

...Editor

There Are No Philosophers in Foxholes! But Maybe There Should Be . . .

Jennifer L. Hansen, Ph.D.

This semester I am lucky to be teaching a Philosophy of Psychiatry course. The students are engaged and the discussions never end when the hour is up. One student in my class has a cousin who works at a well-known psychiatric facility. She disclosed this to me in an early conversation about why she would love to *major* in this course. I was eager to hear what her cousin thought of the readings and debates, so when she went home for fall break, she discussed the class with him and his colleagues. To my disappointment, rather than show enthusiasm for the course, they dismissed it, and whatever issues (nosology, cross-cultural problems in diagnosis, and ethical issues arising out of new technologies) we might discuss, as irrelevant. On a day when we were discussing Peter Kramer's argument for the permissibility of cosmetic psychopharmacology (an issue Kramer raised precisely to spark the interest of philosophers [see Kramer 2000, 13]), Samantha blurted out: "You see, it is these silly debates that piss off real psychiatrists. No wonder psychiatrists don't respect philosophers!"

I was taken aback by her response, and asked her to elaborate on it in my office. What emerged from our discussion was (1) her mother was battling with bipolar disorder and (2) the psychiatrists she had been talking to pointed out to her, over and over again, that mental illness was real, that psychiatry was a science, and therefore, any debates over classification or the "reality" of mental illness was wasted breath. Philosophers, in their mind, were pseudo-scientists getting tangled up with unsolvable metaphysical questions, or, even worse, adoring fans of Sigmund Freud. Samantha's mother's battle with bipolar disorder clarified to me why she was, at times, quite hostile to the readings in class. In particular, Samantha found Thomas Szasz's work offensive; it was, in fact, her disgust with his claim that mental illness is not "real" that predisposed her to agree with her cousin's colleagues; I feared I had lost her forever.

Ordinarily, I don't dwell much on Szasz's rather hostile and unrefined criticisms of psychiatry. I had taught a brief essay he wrote in response to Christopher Megone's article, "Aristotle's Function Argument and the Concept of Mental Illness" (1998). I expected, actually I had *hoped*, that the students would find the flaws with Szasz's argument. Yet, as a philosopher, I want students to be charitable toward whatever they are reading, so that when they finally do point out the flaws, they do so without devolving into the same strawman arguments they are dismissing. Hence, in a futile attempt to persuade Samantha to be *philosophical* in her evaluation of Szasz's arguments, I unearthed a more basic, primal reason why psychiatrists often dismiss the work of philosophers. Samantha kept insisting that Szasz was an idiot because he didn't believe that bipolar disorder was *real*, and since she knew all too well how real and debilitating it was, she didn't appreciate that he made these arguments or that other students in the class might be inclined to agree. I pointed out that Szasz would not deny the reality of what her mother was experiencing, but would reclassify it as a "brain disorder." A brain disorder is a real disease and hence wrongly classified as a mental illness. Szasz's argument, I pointed out, was not to deny the existence of bipolar disorder, but rather to point out how problematic the notion of mental illness was. Szasz proclaims himself a literalist and therefore argues, "the term *disease* denotes a demonstrable *lesion* of cells, tissues, or organs" (Szasz 2000, 4). Samantha was not interested in this conceptual debate at all. I had wasted my time trying to get Samantha to see the core problem with Szasz, i.e. that he is a "literalist," and trusts the dictionary to be an authoritative guide. Szasz had called mental illnesses "myths" and her mother was suffering from a mental illness, hence, any further exploration of conceptual issues were lost on her.

I imagine that for many psychiatrists, treating patients like Samantha, semantical arguments, like Szasz's, are offensive. After all, they are dealing with patients who are suicidal, violent, or otherwise suffering. They are in the trenches dealing with tragedies and they don't have time to engage some passé intellectual on the merits of the DSM-IV-TR or the proper limits of psychiatric care. Perhaps the saying should go: "There are no philosophers in fox holes!"

Being on the Philosophy side of the Philosophy of Psychiatry field, I am regularly reminded of my non-psychiatrist status. And, while I think I have a lot to learn about the real tragedies that psychiatrists treat and from which patients suffer, as well as the scientific breakthroughs in the field, I would be lying if I said that I always appreciate being reminded of my non-psychiatrist status. It's not easy to hear that your student's cousin and colleagues find philosophers to be irrelevant, trivial, or worse, insensitive. I doubt there are a lot of philosophers out there, especially those interested in ethical issues, who think of themselves as dilettantes. And yet, by virtue of our discipline, we are moving from the messiness of the tragic particulars to the general and abstract; we are often removing questions from the context of a practitioner making life or death decisions in his office, to the more serene halls of academic conferences or classrooms. I wonder, at times, if some of the offense we cause is rooted precisely in our turning real people and real tragedies into "what if" questions?

We are turning case studies into thought experiments and imagining almost science fiction like worlds that seem so far removed from real psychiatric facilities. This is one of the more common criticisms against philosophers, like myself, who are interested in the ethical implications of enhancement technologies. Many a psychiatrist has pointed out that there are no such things as "mood brighteners," or pills that can radically transform personality. Perhaps, for the moment, this is true, but to a philosopher, the very possibility of devising such technology is food for thought. We tend to extrapolate from real cases of illicit Ritalin-use among college students

for enhancement purposes or Human Growth Hormone requests by parents who want their children to be great athletes. While we might be arguing science fiction, for the meantime, we are doing so precisely because the possibility of developing powerful biotechnologies that can re-engineer our personalities is a real consequence of taking seriously the biomedical paradigm. If neuroscience proves to unearth the countless mysteries of human agency, personality and mental illness, then we, as philosophers, must point out that the implications for our most cherished notions: responsibility, free will, and choice will be nothing but "folk psychology," reminding us of our once scientific infancy. The promise of neuroscience threatens to dehumanize us. Carol Freedman succinctly argues ". . . what is at stake is a conception of ourselves as responsible agents, not machines" (1998. 136). While clinicians are hard pressed to see their work as reengineering the human race through psychotropic drugs, philosophers can't help but ask basic questions about what it would mean to no longer treat human beings as able to give reasons for their behavior, to interpret their behavior, and thereby empower themselves to transcend the forces acting on them. If human agency comes in tablet form, then, indeed, we will no longer be selves.

At the heart of the discipline of psychiatry is the profound mind-body problem that has haunted philosophers for centuries. This very question might turn out to be a pseudo-question if neuroscience remaps our psychology to the brain states and other physical systems, rendering any talk of mental states meaningless. 'Mental states,' and furthermore, subjective experience, will be publicly accessible. Is it true that psychiatry is restricted solely to the observable, to what is publicly accessible, and therefore what is material? While psychiatrists, like the colleagues of Samantha's cousin, see mental illnesses in terms of brain states aided by new advances in neuroscience, questions of what a mind consists in, what the subjective experience of the patient is, and whether or not we can adequately understand all mental disorders in terms of the body persist. These questions are not unique to psychiatry, but they seem all the more pertinent since many psychiatrists are making decisions about treatment without perfect knowledge of what exactly they are treating; they don't always have tests to run or brain scans to interpret. They rely on their clinical experience and judgment. Psychiatrists, just like philosophers, are products of their culture: they pick up prejudices and they inherit from their culture clues for delineating appropriate from inappropriate behavior. In the absence of decisive evidence that what psychiatrists are really dealing with is diseased brains, philosophers still wonder to what extent the profession of psychiatry is grappling with the age-old problem of other minds? To what extent do we really get access to the subjective experience of others? How much of the mystery of mental disorders can be unraveled, and how much are we helpless in the face of them? It's tempting for a philosopher, like myself, to see the biomedical turn in psychiatry, as in part motivated by a distinct desire to be above reproach. Given how perplexing are the questions of other minds or of what counts as 'normal' behavior, retreating to what can be quantified and objectively known is comprehensible. Another way to understand this move is to think of it in terms of Thomas Kuhn's notion of "normal science" (1970, 35-42) The biomedical model is now the way things are done in psychiatry; Freudianism and phenomenological approaches died with the DSM-III. Once something becomes "normal science" there is no time for philosophical debates.

While Szasz's work is less and less salient to conceptual debates in psychiatry, he did inspire the move by Robert Spitzer and Jerome Wakefield to give a legitimate, scientific basis to the DSM. Psychiatrists responded to the claims that they were nothing more than agents of the state, locking people up against their wills, filling them with dangerous drugs, and on no other basis than to punish deviants. The DSM-III was the rebirth of psychiatry in the biomedical paradigm; it gave psychiatry "street cred" with other medical specialties and it initiated *real* research agendas. If only I could show Samantha's cousin and his colleagues the amazing work that philosophers have done to either improve on Wakefield and Spitzer's move, or shore up psychiatry against attacks by those who claim it a pseudo-science, or to clarify that all medicine involves values (Fulford 1990; Sadler 2005). In the pages of *PPP* are articles discussing what kind of kinds mental disorders are (Haslam 2003), how wrongheaded the realist project of "cutting nature at its joints is" (Zachar 2001), as well as more subtle accounts of what it means to say that a mental disorder class is valid (Thornton 2003). How unfortunate that my only contact with these psychiatrists was Samantha's understandable anger with Thomas Szasz.

Perhaps the result of all this labor—

AAPP Annual Meeting 2008

Political Extremism and Psychopathology

May 3 & 4, 2008
Washington, D.C.
(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 3 & 4, 2008 in Washington, D.C.. This meeting will be devoted to the theme: Political Extremism and Psychopathology.

Recent world history has been shaped by a wide range of extreme political passions often finding expression in acts of violence. Abstract ideologies have fueled many fanatical combatants in polarized conflicts pitting fascism against communism, statism against anarchism, nationalism against internationalism, and secularism against divine right.

The emerging discipline of psychohistory questions what role, if any, psychopathology plays in the political lives of extremists? The annual meeting of AAPP will address this issue.

Possible relevant topics for consideration at the meeting include: Are there coherent ways of distinguishing between healthy and pathological political ideologies? How might one demarcate such boundaries? Who should be empowered to make those distinctions? If the normative values of a society shape its perspectives on mental hygiene, then how can the psychiatric experts of any culture be trusted with a "scientifically" impartial assessment of politically deviant dissenters?

The AAPP invites authors to submit abstracts of proposed papers dealing with these or related subjects. Preference will be given to submissions grounded in empirical fact or philosophical theory rather than political positions. **Abstracts should be no more that 600 words in length and should be sent via e-mail before November 15, 2007 to the program chair, Donald Mender, M.D., at donald.mender@yale.edu. Notices of acceptance or rejection will be distributed on January 1, 2008.**

the legitimization of psychiatry—is that psychiatrists now believe that what they do is indeed above reproach. That is what it means to have become a "normal science," the philosophers are told to go play somewhere else. Unless there is a new crisis. The renewed and revived attack on evolution might be an interesting case study. The scientists, up to their elbows in research, didn't have much to say to the Intelligent Design crowd. They dismissed this as the ramblings of wacko religious types, or scratched their heads in dismay. How could anyone attack the legitimacy of evolution? Who came out to help? The philosophers. All of a sudden philosophers were needed to explain exactly why evolution and Intelligent Design were not different versions of the same thing. The philosophers cleared up confusions over what the word "theory" meant, why the principle of non-falsifiability is important to science, and what counted as legitimate evidence. The lesson to draw here is that philosophers are nettlesome amateurs in times of peace and prosperity, but when science gets challenged, and by folks virtually endorsed by the President and his administration, then the philosophers are indeed good chums to have around.

The new age of antidepressants threatens to put psychiatry in another crisis, which may be why psychiatrists are stubbornly insisting that the work of philosophers is irrelevant to the real work of psychiatry. While Kramer first set out to ask an interesting, perhaps harmless, question about the legitimacy of giving antidepressants like Prozac to the "worried well" to enhance certain personality characteristics, the terrain on which he first posed this question has changed dramatically. In 15 years, antidepressant sales have skyrocketed, along with diagnoses of depression, social anxiety disorder, and insomnia. All of a sudden it seems like *everyone* has some kind of mental disorder. This phenomenon has caught the attention of the same sort of critics that recently launched an attack against evolution. The President impaneled his Council on Bioethics, headed by the well-known conservative intellectual, Leon Kass. Under Kass's stewardship, the council put out a report entitled *Beyond Therapy: Biotechnology and the Pursuit of Happiness* (2003), which came down on the hubristic impulses to enhance the "worried well," charging such psychiatrists with a kind of God complex. Michael Sandel, a political philosopher at Harvard University, followed up on the report with a piece in the *Atlantic Monthly* entitled "The Case Against Perfection" (2004)," wherein he argued "the deeper danger is that [enhancement and genetic engineering] represent a kind of hyperagency—a Promethean aspiration to remake nature, including human nature to serve our purposes and satisfy our desires . . . And what the drive to mastery misses and may even destroy is an appreciation of the gifted character of human powers and achievement" (54). Most recently, Ronald W. Dworkin, a research fellow at a conservative think tank, The Hudson Institute, published a scathing critique of psychiatry and its abuse of biotechnology entitled *Artificial Happiness: The Dark Side of the New Happy Class* (2006).

At the heart of these new critiques of psychiatry is an old theme: that the DSM is unscientific; that the boundaries of what is abnormal have expanded to include normal states; and, that psychiatrists are abusing their power and treating people who do not need medical help, but rather need to reevaluate their lives. While these criticisms may not have penetrated those operating under the assumption that psychiatry is "normal science," the reality is that dissatisfaction and concern with our culture's preoccupation with psychiatric drugs is stirring up a lot of concern. While I have pointed to critics from the right, there are also critics on the left: notably, feminists concerned that once again psychiatry is pathologizing femininity (see Metzl 2003), sociologists concerned with the "naturalization" of psychiatry as a science (see Kutchins and Kirk 1997), and journalists, such as the *Washington Post's* Shankar Vedantam (2005), who point out how racism and cultural difference skew mental illness diagnoses.

The hope is that philosophers and psychiatrists can form a partnership to counteract the growing critics of the field. Philosophers can play a useful role in clarifying conceptual confusions, demonstrate the weakness of some of the arguments made against psychiatry, and the flawed nature of the critics assumptions. Much of the conceptual confusion, not surprisingly, comes from the public's failure to understand science and hence be easily exploited by the horrific scenarios trumped up by the critics. Moreover, precisely because the philosophers are not in the trenches, having to make critical and quick decisions, we have some time to help psychiatrists, in their serener moments, think about what is good care and what their proper role is in delivering that care. I hate to think that we would be useful only in times of crises. And, I should point out that there are plenty of psychiatrists and philosophers engaged in fruitful dialogues within this very organization. I do think, nonetheless, that philosophers play a very important role for scientists in times of crisis. The crisis is generally not generated from within, but rather the product of outside political forces challenging the legitimacy of the entire field. If I can get my students, especially Samantha, to buy into the idea that psychiatrists might need philosophers, and even find them valuable allies, then I will have made one small step toward a happy reconciliation.

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A Bottom-up, Pragmatic A Bottom-up Approach to the Philosophy of Psychiatry

David H. Brendel, MD, PhD

Jennifer Hansen is to be applauded for writing an intriguing account of her interactions with Samantha (a student in her philosophy of psychiatry course) and a thoughtful set of reflections on her experience as a philosopher working in our cross-disciplinary area of inquiry. It is unusual and refreshing to read such a straightforward, experience-near piece of work from an academic philosopher. Hansen's capacity to engage theoretical and practical concerns helps to enliven a critical, but often neglected, debate about the role of philosophers and the role of psychiatrists in the contemporary philosophy of psychiatry. I would like to contribute to this debate by describing some criticisms I have of Hansen's interactions with Samantha, and build on these criticisms by offering a description of my own approach to our field, which is rooted in philosophical and clinical pragmatism.

A problem in Hansen's pedagogical interactions with Samantha is that Hansen assumes a "top-down" approach to teaching the course material. Because of her mother's battle with bipolar disorder, Samantha has experienced first-hand the painful reality of mental illness. So it is not surprising that Samantha takes some offense to the suggestion that mental illness may not be "real." Rather than taking this concern seriously, however, Hansen assumes the dismissive and highbrow attitude that Samantha is not adequately philosophical in her approach (Hansen writes, "I feared I had lost her forever"). Hansen's presumption is problematic, insofar as she fails to recognize that Samantha may be poised to ask an important set of philosophical questions that emerge from the belief that mental illness is real. Samantha may be curious, for example, as to why society does not regard bipolar disorder as a legitimate illness, fails to provide necessary funding to treat it, and stigmatizes individuals (like Samantha's mother) who suffer its potentially devastating consequences. Or Samantha may be curious why some psychiatrists narrowly conceive of bipolar disorder as a derangement of brain functioning that only necessitates psychotropic medications as primary treatment, rather than conceive of it as a complex disorder of the brain and psychosocial milieu that may call for psychotherapy as well. A more "bottom-up" approach to teaching her philosophy of psychiatry course might have led Hansen to meet Samantha closer to where she was in her student's understanding of the field. In that way, the instructor as well as the student might have been in a better position to challenge and reevaluate their own strongly held beliefs.

Along similar lines, I am skeptical of Hansen's "top-down" delineation of the so-called "enhancement" debate as a central problem currently facing psychiatry. Being a pragmatist, I am not convinced that a problem really exists until I (or other practitioners) witness it emerging as one – and the "enhancement" problem, as I see it, is a problem for speculative philosophy but not for real-world clinical psychiatry. Hansen writes that the possibility of developing medications that could serve as "mood brighteners" and could "radically transform personality" should be considered "food for thought." That may be the case in a philosophy classroom. But if academic philosophers like Hansen expect to be part of a debate about what is really going on in psychiatry today, then they need to be less preoccupied with such far-fetched scenarios and instead roll up their sleeves and engage in the messy problems that patients and psychiatrists are currently facing. Again, a "bottom-up" approach to the philosophy of psychiatry might lead philosophers like Hansen to listen more closely to the problems that patients, their family members, and their clinicians are facing day-to-day. In my years of clinical practice with a broad range of patients, I have

never had a patient or family member voice a philosophical or ethical concern that a prescribed psychotropic medication caused a worrisome "enhancement" of personality. Quite the contrary, the perennial concerns I hear are that the medications are not working well or are causing troubling side effects such as sedation and weight gain – far from the specter of "enhancement"! In the years ahead, I hope talented philosophers like Hansen will increasingly turn their attention to contemporary concerns, such as how to practice psychiatry in the face of scientific uncertainty about the mind and brain, poorly systematized models of psychiatric explanation, and growing sociocultural diversity amongst patients.

As a practicing psychiatrist with doctoral training in philosophy and post-doctoral training in professional ethics, I have been striving over the past decade to bring both the theoretical and practical dimensions of my training to bear on the most pressing problems of contemporary psychiatric practice. While my dual training at times leaves me feeling not particularly at home in either philosophy or psychiatry, for the most part I have found the two dimensions to be synergistic and complementary. When I began to spend most of my time practicing psychiatry nearly 10 years ago, I found myself becoming less focused on the theoretical questions in phenomenology, philosophy of mind, and philosophy of science which had concerned me previously. Clinical practice and post-doctoral training in ethics prompted me to question what a "bottom-up" approach to philosophy could offer psychiatrists and the patients who come to their offices seeking help.

It was in this context that I turned my attention to pragmatism – its classical American origins in the work of thinkers like Williams James and John Dewey, its neo-pragmatic transformations in the work of thinkers like Richard Rorty, and its recent applications in pragmatic bioethics. Drawing on the richness of these traditions, I have advocated for "clinical pragmatism" in psychiatry in a series of papers (e.g., Brendel 2003) and a recently published book (Brendel, 2006). The core of pragmatic psychiatry is rooted in the "four p's" I outline there: a *practical*, results-oriented approach to clinical problems that does not get bogged down in abstractions (such as the "enhancement" question); *pluralistic* use of many sciences and humanities to help patients heal; robust *participation* of patients (and family members, when relevant) in formulating diagnoses and treatment plans; and a *provisional* sensibility about current psychiatric science and our capacity to explain and predict complex human activity. This pragmatic model of psychiatry reflects my still evolving attempt to integrate philosophy and psychiatry in a coherent way, and gives some indication of how I aspire to work with my patients every day. I have little doubt that I and other practitioners will obtain valuable assistance in this enterprise if and when philosophers of psychiatry like Hansen throw themselves more wholeheartedly into the practical debates raging today among psychiatrists and patients as much as they have devoted themselves to relatively abstract debates such as the one about "enhancement."

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Clinical Theory, Neuroscience, and Philosophy: Finding the Foxhole

Douglas Heinrichs, M.D.

Jennifer Hansen has done us a service in making explicit an underlying tension between psychiatrists and those philosophers reflecting on what psychiatrists do. She offers a number of possible explanations as to why some of us psychiatrists have difficulty seeing the reflections of philosophers as helpful or even relevant. They seem to condense into two main themes. The first, simply put, is that psychiatrists have bought a narrow biomedical model based on neuroscience, motivated by a desire to be "above reproach," to have credibility with other medical specialties, and to get on with "normal science" with as little distraction as possible. In doing so, we turn our back on phenomenology, psychodynamics, an appreciation of social context and common sense. While some psychiatrists undoubtedly show some of these features, it is a caricature that does not accurately describe the psychiatrists I know.

Psychiatrists are indeed excited by advances in pharmacologic and other somatic treatments, but they are unlikely to deny the importance of other interventions or to posit that a patient's DSM-IV diagnosis says all that is important to know about a patient. To the extent that some psychiatrists practice as if they believed this, it is likely to reflect practical pressures imposed by managed care policies – a situation bitterly decried by psychiatrists themselves. Nor do most psychiatrists adopt a reductive materialism as part of embracing a simplistic neuroscience. It would make for an interesting survey, but I suspect that most psychiatrists in fact hold a rather unreflective dualism as their philosophy of mind. In short this first theme generates something of a straw man that most of us simply do not see when we look in the mirror.

The second theme that emerges revolves around the possibility that the speculations of philosophers may seem too removed from the clinical realities with which the psychiatrist wrestles. Hanson wonders whether philosophers "…by virtue of our discipline, …are moving from the messiness of the tragic particulars to the general and abstract; we are often removing questions from the context of a practitioner making life or death decisions in his office, to the more serene halls of academic conferences or classrooms. I wonder, at times, if some of the offense we cause is rooted precisely in our turning real people and real tragedies into 'what if' questions?" Here, I believe, is an important part of the problem. To the extent that the philosopher claims to be speaking to the psychiatrist, to be offering conceptual clarification of the psychiatric activity, she should be addressing the theory of a clinical discipline. As such, moving to the "general and abstract" should not imply "removing questions from the context of the practitioner." The point of any theory of a clinical practice – a *techne,* as opposed to an *episteme* – is to inform the particularity of the clinical encounter. Discussions that do otherwise may be valuable in some other way, but they are not about the theory of psychiatry. As a clinical discipline, psychiatry is informed by a number of sciences – psychology, neuroscience, psychopathology, sociology, anthropology, etc. – but should not be identified with any of them. One can argue whether neuroscience is having an excessive influence on psychiatry currently, relative to other informing sciences, but psychiatry is not neuroscience. The latter seeks to generate generalizable knowledge and principles as to how the nervous system functions; the former aims to optimally treat individuals.

Hansen, as do many philosophers, tends to blur this distinction, resulting in

considerable conceptual confusion. (Interestingly, psychiatrists, when trying to present what they do to society at large, often fall into the same error.) By illustration, consider the flow of one of her arguments: Philosophers "…tend to extrapolate from real cases …precisely because the possibilities of developing powerful biotechnologies that can reengineer our personalities is a real consequence of taking seriously the biomedical paradigm. If neuroscience proves to unearth the countless mysteries of human agency, personality and mental illness, then we, as philosophers, must point out the implications for our most cherished notions… The promise of neuroscience threatens to dehumanize us….to no longer treat human beings as able to give reasons for their behavior, to interpret their behavior, and thereby empower themselves to transcend the forces acting on them. If human agency comes in tablet form, then, indeed, we will no longer be selves." While it is far from evident that any possible development in neuroscience proper would in fact have such dire implications (I would strongly argue that they would not), my point here is something else: The slide from talking about what psychiatrists do to an abstract theory of neuroscience goes unnoticed and creates mischief. One hallmark of confusion between talking about a *techne* as opposed to an *episteme* is the confounding of questions of what we can do with questions of what we ought to do. Hanson's biggest sense of threat to our sense of self has nothing to do with whether psychiatrists in fact prescribe psychotropics in any given situation. It rather relates to whether a theory of neuroscience is true that makes such interventions possible in theory. If it is true that the nervous system is such that what we call human agency and personality is totally controllable by the ingestion of chemicals, leaving no remainder for influences at psychological and social levels, the problems that concern Hansen already exist, even if no one ever swallows a single dose. We are already deluded about our nature and are simply chemically controlled, albeit by those chemicals that nature happens to dish out rather than those we choose to incorporate. Indeed, what would it then mean for such a chemical system to "choose" to take in additional chemicals to alter its mode of operation? (The error here has interesting parallels to a common form of "philosophical resistance" to medication seen in many patients, e.g. the bipolar patient who won't take lithium because to take it means she has the illness and she doesn't want to have it. Of course if she has it, that is not altered by whether or not she ingests lithium. Whether or not to take lithium should be based on other considerations.)

Discussions of the philosophical implications of what is possible in psychopharmacology are really discussions about the theory of neuroscience, although they certainly should be of great interest to psychiatrists. The proper range of discussions about psychiatric theory has to do with which, of the interventions we can do, we should do with any given patient, and what principles should guide those decisions. These are the decisions psychiatrists face every day. To attempt to make them responsibly, we draw not only on knowledge derived from neuroscience, but psychologically and sociologically derived information as well, all integrated within a phenomenologically based understanding of the individual patient. And this represents the explicit ideal of the modal practicing psychiatrist. It is not just a stop gap strategy because we "don't always have tests to run or brain scans to interpret." It is simply not true that the "biomedical model is now the way things are done in psychiatry; Freudianism and phenomenological approaches died with the DSM-III." (Freudianism provides an interesting instance of the mischief caused by confusing an *episteme* with a *techne*, as psychoanalysis contains attempts at both – psychoanalytic metapsychology and clinical theory respectively. Useful discussions require that they be conceptually separated. The clinical theory is showing many more signs of life than the metapsychology.) In fact, a sufficiently nuanced understanding of the biological can integrate much of what is usefully construed as psychological and phenomenological and resists any simple-minded reductionism. I have suggested elsewhere (Heinrichs, 2006) a basis for such a complex model and its implications for the practice of psychiatry in a consideration of chaos theory.

All of this is not to deny that much psychiatry, as currently practiced, is a hasty prescription of psychotropic medications based on crude diagnostic characterizations with little regard for the complex needs of individual patients. But the problem is not at the level of theory, but rooted in social and economic forces that encourage psychiatrists to limit their work to considerations of medications alone conducted in increasingly shorter units of time, while relegating other aspects of care to other mental health workers. It seems to me that psychiatrists as a group and as individuals have been much too passive in accepting these changes, and a vigorous debate of the ethical implications of accommodating to these changes is warranted.

Nor would I deny the validity and fascination of the philosophic engagement with the implications of neuroscience. These pose important considerations for society at large as well as for issues of great interest for most psychiatrists. But they are fundamentally different from philosophical attention to psychiatry as a discipline itself. In failing to make this distinction clear, Hansen in fact make errors not unlike those made by the President's Council on Bioethics itself. Small wonder that sharing the foxhole can get a bit dicey. But continued discussions of the sort likely to be stimulated by Hansen's paper between psychiatrists and philosophers will go a long way to making such shared occupancy satisfying and productive.

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Creating the Conditions for Dialogue between Philosophers and Psychiatrists

Christian Perring, Ph.D.

Jennifer Hansen speculates why psychiatrists are so hostile towards philosophers, and offers a plea for the importance of the philosophical viewpoint. My experience has been somewhat different from Hansen's. The psychiatrists I have met through AAPP and in other venues have generally been sympathetic and friendly, and indeed they are often vitally interested in philosophical issues. The least positive interaction I have personally experienced occurred several years ago at a Ground Rounds I gave at a University Medical School Department of Psychiatry, where the audience consisted mostly of psychiatric residents. Their response was to a large extent disinterest: they had little enthusiasm for the philosophical questions raised by their practices, and were clearly much more concerned with how to cope with their patients. Yet even this group was not hostile to or even suspicious of philosophy of psychiatry; they just did not see the relevance to their own work. By way of contrast, I once attended a lecture by a colleague who specialized in philosophy of physics to a group of physicists. I was quite taken aback when they did not let him get more than

five minutes into his talk without raising objections, accusing him of failing to understand physics, and demonstrating a homogeneous attitude of contempt for his efforts to understand the metaphysical underpinnings of their field. It made me grateful for the relative friendliness and openness of psychiatrists.

Indeed, in doing research on philosophy of psychiatry, one may experience more suspicion and muted derision from other philosophers than psychiatrists, at least in the United States. As a relatively new field, philosophers don't know what to think of it, and whether it should count as part of medical ethics, philosophy of psychology, or some other area such as philosophy of psychoanalysis. Academic philosophers tend to be wary of fields of study that do not fit easily into existing categories. Despite the fact that the journal PPP has been in existence for well over a decade and there are now book series in philosophy of psychiatry with both Oxford University Press and MIT Press, there's still rather limited interest in the field. As far I know, there has been no job search in any philosophy department in the USA where the advertisement spelling out what the department is looking for has even mentioned philosophy of psychiatry. Sometimes the AAPP group sessions at American Philosophical Association conference meetings are well attended, but quite often, even with rather well-known names in the field on the program, attendance is sparse. While I view philosophy of psychiatry as a rich and fascinating field of research and there are many encouraging signs of the field establishing itself, there is still some way to go before the field becomes well established within academic philosophy.

It would be a mistake to give the impression that all psychiatrists are open to interdisciplinary debate about their field. In the context of a disability studies conference focused on mental health problems, I recently saw a psychiatrist become quite aggressive and dismissive of the critical claims made by members of psychiatric survivor groups and patient advocacy groups, leading to some heated exchanges during question periods and in between sessions. However, in a different context, at a meeting of the NYC AAPP group last year, when we had a well-known psychiatric critic giving a presentation, the mental health professionals were rather silent while the speaker accused well-known names in the field of being dishonest, cowardly, and lacking academic integrity. Some of these professionals later told me afterwards that they did not appreciate the tone of the speaker's talk.

When meeting with psychiatrists for the first time, I have found they can feel unsure how to relate to philosophers. There can be a sense that one has to get their trust, and that one needs to show that one is not a flake who avows the ideas of Deepak Chopra or a radical who denounces the whole practice of psychiatry. I suspect that the caution of psychiatrists arises from experiences with vociferous critics of psychiatry. However, once one gets over that initial hurdle, there can often be a great many mutual interests. The trouble both philosophers' and psychiatrists' experience in talking about philosophy of psychiatry is in finding a common vocabulary; technical jargon from both sides may create misunderstandings or simple lack of comprehension. It takes time spent in sustained dialog to get confidence that both sides with very different trainings are really understanding what each other is trying to say.

As Hansen points out, psychiatrists may appeal to their psychiatric status and even use their status in a debate as a trump to win or at least end an argument. Used as an ad hominem argument, it is an illegitimate move in an argument. However, I have a good deal of sympathy with those psychiatrists who think that philosophers need to be aware of the lived reality of clinical practice before they can be in a strong position to start making judgments about psychiatry. There are several reasons for this. First, it is important to vividly understand how people with severe mental illnesses actually behave, and clinical vignettes or case studies very rarely convey this very clearly. Watching documentary videos or dramatized portrayals provide some sense of the experience, as do memoirs of mental illness. However, spending time observing on a psychiatric ward has been at least for me an invaluable experience, because it helped to fill in the unstated details that one does not get from more indirect accounts. Furthermore, at the places I have been able to observe (Georgetown University Hospital and the Mayo Clinic) I was able to see the interactions between the psychiatrists, other doctors, social workers, nurses, patient and others. One gets a far more complete picture of (some brands of) psychiatric treatment when visiting a facility for a week or two, being able follow cases from initial intake to the departure of the patient, than through learning via other modes. Finally, having such experience helps to provide some points of mutual reference when talking with psychiatrists about the philosophical issues raised by the psychiatric practice, and helps to reassure them that one's philosophical ideas are not completely driven by theory or ideology.

So I am rather more sanguine about the relation between philosophers and psychiatrists than Hansen. Of course, it may be some time before there are publications of papers by philosophers in the American Journal of Psychiatry, and there are clearly institutional divisions between the two groups. I don't, however, recognize her depiction of psychiatrists as a group who believe that what they do is "above reproach," nor do I see much sign that the new age of antidepressants is threatening to put psychiatry in a state of crisis. Certainly, psychiatrists must believe that on the whole they have the means to help their patients, and many psychiatrists have concerns about the direction that modern psychiatry is taking, but it was ever so. I am grateful for my experience that so many psychiatrists are very happy to engage in discussion with philosophers, once they have reassured themselves that the dialog is one that can be productive and thoughtful.

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Philosophers, Foxholes, and Medics

Nancy Nyquist Potter, Ph.D.

Jennifer Hansen is correct that students whose loved ones are mentally ill can become frustrated if the questions posed in a course on philosophy and mental illness are too esoteric. But frankly, students in general might view philosophy as abstract and useless. We do continue to ask questions such as "If I turn my back to the door, will the door still exist?" and some of us spend our lifetime on metaphysical conundrums like that. Hansen says that "by virtue of our discipline, we are moving from the messiness of the tragic particulars to the general and abstract." And it is true that this is the modern history of philosophy.

But philosophy does not have to be done this way. Even when I was in graduate school, I worried that my training in ethics would remove me from everyday problems in living that people face, so I became a certified crisis counselor. I worked as a team in 12-hour shifts for five years. In fact, that is where I first heard counselors use the term "borderline" in a pejorative way, leading me to now do most of my research on Borderline Personality Disorder. Then, a few years ago, I sat in on group sessions with sex offenders in a state prison so as to see first-hand how psychotherapists tried to teach them empathy for their victims and thus curb recidivism.

But I still worried that my paper education was not fully giving me a sense of what it is like to struggle with mental disor-

der, or to try to treat someone with mental distress. So for the past three years, I have been shadowing psychiatrists at their work.

I started going on rounds once a week with the attending in the in-patient psych ward. It was there that I received my first jolt of theory versus practice in psychiatry. I had written an article on self-injurious behavior. After seeing the damage a patient did to her body, though, I have been forced to rethink my theoretical position. Similarly, I had written a chapter on BPD anger, arguing that anger should be considered at least possibly justified. But a patient on the floor whose rage was quick and dangerous, calling for six-point restraints, greatly enriched my understanding of BPD anger.

I spend one morning a week in Emergency Psychiatric Services as part of the health care team. Here I see patients before they are sent upstairs, to the psych ward, or to a crisis stabilization unit, private hospital, or shelter. I see the attending psychiatrist work with a patient to determine how best to help the patient. It grieves me to see such agony that patients bring to EPS and, sometimes, how unable or unwilling they are to help themselves. By sitting in on morning dispositionals, I have learned more than can be recorded, both about mental disorders and about psychiatrists' work. I have the opportunity to ask questions of the attending, so I learn more each week about diagnosis and treatment. I have even repeatedly been invited to ask questions of the patients.

By now I have observed a number of psychiatrists, the most recent of which is Rifaat El-Mallakh. Every one of them has treated me not only with respect, but with the expectation that I have something to offer them. Dr. El-Mallakh has praised the way my philosophical perspective helps him to see things in a new light. It is not my experience that "psychiatrists now believe that what they do is indeed above reproach," as Hansen writes. Instead, I see them struggling like everyone else to do the right thing by another human being.

I am not describing my experiences to be self-congratulatory. I am writing, instead, to say how absolutely crucial it is for philosophers to obtain experience in hospitals and clinics. While I, too, believe that philosophers have important tools to analyze concepts and arguments, I think that psychiatrists (and students) will take us more seriously if we have knowledge by acquaintance, not merely knowledge by description. While I am not "in" the foxholes, I am very close by. And it's important to remember that, although using the war metaphor of foxholes, we are really all on the same side—with the desire to understand human experiences and relieve human suffering.

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Empiricism and the Craft Nature of Science

Mark D. Rego, M.D.

Early in my post-residency career I found myself dissatisfied with the theoretical prospects offered by the standard paradigms within psychiatry. Cognitive therapy, self-psychology and descriptive psychopathology—my early hopes to replace simplistic receptor-based neurophysiology and the sclerotic house of cards of psychoanalytic theory—had peaked, in my view, in their abilities to explicate psychopathology, its causes, treatments and implications. Certainly each had something to offer, psychodynamics replaced analytic theory and eclectic approaches happily prevailed.

Nonetheless I remained curious about the premises that formed the underbelly of what I was doing and how this all mattered in the then, 1990's. Occasionally I'd get a clue and follow the path through bibliographies. Inevitably I bumped into things like; "Hermeneutics," "Phenomenology" (with a capital "p"), "false dichotomies" and "natural kinds." After a few discussions with a colleague (the editor of this Bulletin) it became clear that I had to bite the bullet and do a lot of reading. He recommended Richard Bernstein's *Beyond Objectivism and Relativism: Science, Hermeneutics and Praxis* as a starting point.

Even though it caused some strain in my thinking muscles, I couldn't put it down. Bernstein described an area of study in which people thought about thinking and questioned the very premises of seemingly obvious fact. The thinkers in *Beyond Objectivism…* were digging up the conceptual foundations of thought and experience in order to extend intellectual fulcrums and trace out their implications. I liked these guys. A decade later, after a steep learning curve and much patience from our editor, I could read, talk with and use the materials of philosophers.

Perhaps the best way to describe philosophy's effect on me as a psychiatrist is Hansen's explanation of why her students should study Szasz. Rather than dismiss him with the same hostility and ignorance with which he dismisses psychiatry, we should understand and be able to articulate why he is so wrong. In a roundabout way patients and their families will ask us. We ought to be able to communicate our perspective without retreating to mere authority.

Szasz will serve a dual purpose for me as he also provides a point of departure for some criticism of the present state of the philosophy of psychiatry. Within this field of study Thomas Szasz is certainly the world's most discredited man. And yet he uncritically appears like Aristotle as the basis for an improbable number of discussions about psychiatry. To draw the divide that is the subject of this issue of the Bulletin; I agree with Samantha about Szasz, I do not think most philosophers do.

To flesh out what I think is wrong here I'll take examples from my own practice of psychopharmacology and my very small amount of writing on the subject. During the week I see quite a few people in my office and on weekends sift through quite a bit of mental health literature looking for clues on how to be more helpful. I am alarmed in both cases. It does seem like people are falling apart and the psychiatric literature supports an increase in mental illness in recent decades. I do many second and third opinions and am shocked by the way the biomedical model has hijacked clinical thinking. The mountains of biological data about psychiatric illness may help treat such problems—they have in fact done so only in very limited ways so far—but they certainly do not explain much of what is happening to someone apart from saying it is biological. Trends in diagnosis are also troubling. Everyone these days who is moody or over-spends is Bipolar. A few years ago they had ADD and before that Multiple Personality disorder (this last sad episode was undone with the help of philosopher, Ian Hacking (1995).

But rather than take each of these problems and put them under the scrutiny of reason and data (as Hacking did) there is an overdependence on reason alone and a surprising lack of awareness of pertinent research. In place of such knowledge are erroneous assumptions extracted from the empirical literature. For example, Hansen states that she is now aware that antidepressants are not mood elevators, but she claims that this is not the point because philosophy examines the "what ifs." Fair enough, though she may be alone in this perspective. I recently wrote a paper on the philosophical implications of antidepressants (Rego 2005). In preparation for this paper I took an extensive dip into the enhancement literature. "Mood elevators," "cosmetic psychopharmacology," "cognitive enhancers," "memory change" and the "alteration of personality" by psychotropics were everywhere. But not as "what ifs." These are discussed as present realities. To be clear, none of these things exist (at least not legally, safely or lasting more than a few hours). But the conflation of these speculations with existing therapeutics is at the basis of much of the critique of therapeutic agents.

Other questionable assumptions include those regarding critiques of diagnostics. There is much to criticize about diag-

noses like "Road Rage Disorder" and Nocturnal Binge Eating Disorder," and checklist approaches to care. But there is nothing to be gained by conflating normative experiences, such as demoralization and grief, with psychiatric diagnoses (you can have either one and be depressed, as decades of research on precipitants in depression and complicated bereavement testify). Nor is there support for the idea that psychiatric categories exist on stable continuums with normal experience (they are modally different; see the extensive literature from the ECA Studies I and II and the National Comorbidity Studies I and II). A recent issue of Philosophy, Psychiatry and Psychology (2006) featured an extensive discussion on Minimal Cognitive Impairment. Many of the arguments (all critical) were based on premises that ran counter to the basic research and history of the subject (as was revealed by an included commentary).

What is up here? I don't think the problem is, as many have apparently suggested to Hansen, that philosophers are not psychiatrists. The problem is a lack of appreciation of the essential craft nature of science and to a larger degree medicine. (Ravetz 1995). Science is learned by extensive background study, apprenticeship and a continuous dialogue between the clinician's experiences and progress in the literature (or the same with colleagues). Knowledge in psychiatry exists as an arc from this training and experience to a single case. It only exists when there is a decision about an "n" of one, i.e. a patient. Principles are induced, facts uncovered and information disseminated all for this purpose. As these decisions are highly conceptual a clinician must know where she stands on her concepts (enter philosophers). But philosophers must know where clinicians stand, and that is between many patient encounters and literature development that demands immersion. Such a perspective cannot be gained from the tendentious cherry-picking of literature that goes into mass-market publications, nor from distorted information about drug side-effects and not even from black box warnings.

When I was a psychiatric resident I saw a new staff member in the mental health clinic at the VA hospital. Judging by his style of dress I assumed he was a graduate student (i.e. no money). So I sauntered over to welcome the new kid on the block and made friendly and perhaps a bit paternalistic chit-chat. Only with some prodding did I learn from him that he was Jonathan Lear, the chairman of philosophy at Yale. He had decided to become a psychoanalyst and though he wasn't sure he'd actually have a clinical practice, let alone one with the kinds of chronic patients at the VA, he was sure that it made no sense to do this without immersing himself into the lives of patients and clinicians.

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Tough Talk About a Tough Job

John Z. Sadler, M.D.

Thanks to Professor Hansen for her student-inspired meditation about the role of the philosophy of psychiatry. Currently I'm teaching my first undergraduate course in my life, entitled "*Technology and Mental Health*" and I can vouch for the fact that my small honors class (14 students) really digs talking about the philosophy of psychiatry.

I was most haunted by the dismissal of student Samantha's enthusiasm for the philosophy of psychiatry by her psychiatrist acquaintances. I would like to focus on this facet of Hansen's essay. (Readers may find my editorial elsewhere in this issue of the Bulletin also relevant to this discussion.)

Several key points come to mind in thinking about these dismissals. First is that those of us working within the philosophy of psychiatry field should remember that the prevailing issue for patients and their families is *access to quality care*. Debating the potential for biopsychiatric enhancement is fascinating for us, but from the patient/family perspective this is a remote blip on the radar screen, when their biopsychiatrically impaired loved one is on the streets, hallucinating.

This leads into a second point, which is the importance of stigma and the metaphysical power of mental illness in any discussion in the philosophy of psychiatry, two issues I discuss for a lay audience in the following URLs: http://www.project-syndicate.org/commentary/sadler1 and http://www.project-syndicate.org/commentary/sadler2. Our patients face not just the insult of mental illness but the double insult of stigma. This is mixed in with a set of diseases that affect the very ability to understand and appraise oneself and others. Our culture makes things difficult for all of us in this regard. We can understand the profound sense of offence about Dr. Szasz' writings from the vantage point of the families of the mentally ill. For them, Szasz is the intellectual promoter of stigma, the blamer of victims, a partner to the Scientology movement. Who could take such dangerous talk seriously?

Yet philosophers of psychiatry, and academe, should. Not because he's right but because people do take him seriously. Let us join the voices of protest, wherever they are, with careful analysis and debate. That's what philosophy is for - debating about what really counts.

My second general point is a warning about hubris. Psychiatry's history has a lot to NOT be proud of. Any practitioner of psychiatry knows that the work is cruel and tough, and to be decent and effective is not easy. Rewards are few, and criticisms are legion. However, arrogant proclamations about our science are rarely uttered by our best psychiatric researchers, rather, talking with them betrays a profound humility in face of the complexities we face. Yet, one can empathize with our colleagues who soothe themselves with simple solutions to intimidating problems. Fear often inspires bravado. We need courses like Professor Hansen's to develop new citizens who care about mental illness and the ill, and want to promote a humane, thoughtful psychiatry. Samantha, take that psychiatrist on. Hold him/her accountable. Be skeptical, be tough-minded, be caring.

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The Unexamined Life is not Worth Living: Philosophy as a Natural Component of Self-conscious Psychiatric Practice

Tim Thornton, Ph.D.

It is appropriate that, in characterising the philosophy of psychiatry, Jennifer Hansen starts by mentioning, albeit critically, the anti-psychiatry of Thomas Szasz. Whilst the father of psychopathology, Karl Jaspers, combined psychiatric and philosophical expertise, within the English speaking tradition philosophy and psychiatry went their separate ways throughout most of the twentieth century. But towards the end of that century, it was the rise of the anti-psychiatry movement that prompted a resurgence of interest in psychiatry within

broadly analytic, Anglo-American philosophy.

The reason for this was that a key element of the anti-psychiatric criticism of mental health care turned on a contentious claim about the nature of mental illness: that mental illness does not exist; it is a myth. Such a sceptical claim is paradigmatically philosophical and psychiatrist Thomas Szasz, as one of the main proponents of anti-psychiatry, put forward a number of explicitly philosophical arguments in support of it. (His arguments were not the only resource for anti-psychiatry. But they were both well known and pithily philosophical.) This in turn spurred a philosophical response by both psychiatrists and philosophers putting forward analyses of mental illness to undercut the sceptical argument and thus, partially at least, to justify psychiatric practice.

This brisk recent historical sketch suggests a view of the role of philosophy of psychiatry which also chimes with a widespread historical ambition for philosophy more generally: to be the queen of the sciences, arbitrating what is good and what is bad science. But, whilst that was an influential view until nearly the end of the twentieth century, it has fallen from influence. This is partly as a result of the realization of the impossibility of articulating a substantial prescriptive model of good scientific practice [Kuhn 1970]. But it is also the result of criticisms by philosophers such as Richard Rorty, Arthur Fine and John McDowell of the very idea of philosophy acting as an independent judge of the truth claims of other disciplines [Rorty 1981, Fine 1999, McDowell 1994].

Legislation by philosophy over, but from outside, empirical science has been replaced by more organic relationship between philosophy and other disciplines, a relationship that, in the US at least, has been influenced by the late WVO Quine's advocacy of epistemological naturalism [Quine 1969]. According to the new Quinian orthodoxy, philosophical methods are continuous with scientific methods. I aim here to suggest a less radical position. Whilst philosophical methods are distinct from purely empirical methods – and that is why philosophy has something distinctive to offer – its subject matter is continuous with that of psychiatry.

Hansen herself suggests a positive role for philosophy but only within the earlier framework of philosophy as external legislator. She suggests that, on the model of philosophical defences of the status of evolutionary theory, philosophy can play a role in justifying psychiatry against anti-psychiatry. But it is, I think, a mistake to think that philosophy is primarily either for, or against, psychiatry. The reality is more complex but also much more interesting and useful than that. *Philosophical questions arise naturally within psychiatric theorising*. *Philosophy is thus continuous with self conscious psychiatry.* One consequence of the picture I will sketch is that the relationship in question is best thought of not as that between psychiatrists and philosophers so much as psychiatry and philosophy.

A Different Lesson from Anti-psychiatry

One way to see this is to think again about the reaction to anti-psychiatry. Szasz' main argument turns on the idea that mental illness depends on a value-based norm and that this is in conflict with the idea that mental illness might be treatable by medical means. He says:

> The concept of illness, whether bodily or mental, implies deviation from some clearly defined norm. In the case of physical illness, the norm is the structural and functional integrity of the human body. Thus, although the desirability of physical health, as such, is an ethical value, what health is can be stated in anatomical and physiological terms. What is the norm, deviation from which is regarded as mental illness?… [W]hen one speaks of mental illness, the norm from which deviation is measured is a *psychosocial and ethical* standard. Yet the remedy is sought in terms of *medical* measures that – it is hoped and assumed – are free from wide differences of ethical value. The definition of the disorder and the terms in which its remedy are sought are therefore at serious odds with one another… [Szasz 1972: 15]

Since medical interventions are designed to remedy only medical problems, it is logically absurd to expect that they will help solve problems whose very existence have been defined and establishe on non-medical grounds. [ibid: 17]

This argument is not, however, compelling. The fact that mental illnesses are *identified* via value-laden descriptions of behaviour does not imply that they are *identical* with such behaviour. Thus, although the norms that play an essential role in the identification of mental illnesses may be distinct from those that identify physical illnesses – they are psycho-social, ethical and legal rather than structural and functional - that identifying role does not preclude a causal role for mental illness. Thus it is not logically absurd to expect medical treatment of mental illness and thus the model of mental illness that combines these two features – identification via psychosocial norms and medical treat ability – has not been shown to be false of mythical.

So far this summary of Szasz is in accord with Hansen's hostility to anti-psychiatry. But note that whilst the above argument undermines Szasz' conclusion that mental illness is unreal it does not undermine his key claim that it is constituted by essentially evaluative norms. And in fact most of the interesting response to Szasz – in their conflicting ways, for example, by Wakefield and Fulford – take this, rather than the reality or not of mental illness, to be the main question [Fulford 1989, Wakefield 1999]. Is mental illness value-laden or not? Aside from an anti-psychiatric attack there are a number of other substantial issues of importance to psychiatry that would follow from this such as the extent to which we should expect agreement – or reliability – in psychiatry, especially across different cultures. This in turn leads to issues of public policy with regard to mental health care: what model of recovery is there? Is there a notion of mental health that is not merely the absence of illness and so on? It also leads into more explicitly ethical questions such as how a diagnosis of mental illness can ethically justify involuntary treatment. What is it about *mental* illness that might do this?

The initial question - of whether mental illness is value-laden - is not empirical. It depends primarily on conceptual analysis of the terms involved although it also depends on the empirical facts about what are taken to be paradigmatic mental illnesses. A self-conscious understanding of a central psychiatric concept thus depends on a philosophical analysis. Within the original debate about anti-psychiatry is a question of continuing interest that is continuous with psychiatric practice although it need not be taken directly to threaten the very possibility of such practice. It concerns how best to understand the central subject matter of psychiatry: the treatment of mental ill health. And the resources required for addressing it are conceptual, and thus philosophical, as much as they are empirical.

The idea that the subject matter of philosophy of psychiatry is continuous with, and develops naturally from, the concerns of psychiatry itself can be illustrated through a number of recent debates as diverse as how evidence based practice is best applied to mental health care; or how brain imaging experiments on the timing of conscious decisions impact on the nature of free will. But I will jump right up to date and outline a conceptual or philosophical issue arising naturally from present concerns within psychiatry, which will have to be addressed over the coming years.

The Apparent Tension between Narrative Formulations and Validity

Even a casual observer of intellectual developments in psychiatry will have noticed two growing emphases. One is the suggestion that whilst great advances were made in DSM III and IV in increasing the reliability of psychiatric diagnosis, this may have been at a cost of its validity. Thus the task force carrying preliminary research for the next revision – DSM V – have called for validity to be placed at the centre of the revision process.

> Those of us who have worked for several decades to improve the reliability of our diagnostic criteria are now searching for new approaches to an understanding of etiological and pathophysiological mechanisms – an understanding that can improve the validity of our diagnoses and the consequent power of our preventive and treatment interventions. [Kupfer, First and Regier 2002: xv].

On the other hand, a recent development within the World Psychiatric Association is the advocacy of a 'comprehensive' model of diagnosis. A WPA workgroup charged with formulating 'International Guidelines for Diagnostic Assessment' (IGDA) has published a guideline called 'Idiographic (personalised) Diagnostic Formulation' which recommends an idiographic component within psychiatric diagnoses. This has been put forward within the context of the development of a model of 'comprehensive diagnosis' which is described by Juan Mezzich, President of the WPA, as follows.

> The emerging comprehensive diagnostic model aims at understanding and formulating what is important in the mind, the body and the context of the person who presents for care. This is attempted by addressing the various aspects of ill- and positive- health, by interactively engaging clinicians, patient and family, and by employing categorical, dimensional *and narrative* descriptive approaches in multilevel schemas. [Mezzich 2005: 91 italics added]

Writing in the journal *Psychopathology,* the psychiatrist James Phillips describes a narrative and idiographic addition to conventional criteria-based diagnosis in this way.

> In the most simple terms, a narrative or idiographic formulation is an individual account with first-person and third-person aspects. That is, the patient tells her / his story, with its admixture of personal memories, events and symptoms, and the story is retold by the clinician. The latter's account may contain formal diagnostic, ICD-10 / DSM-IV aspects, as well as psychodynamic and cultural dimensions not found in the manuals. The clinician's account may restructure the patient's presentation, emphasizing what the patient didn't emphasize and de-emphasising what the patient felt to be important. It will almost certainly contextualise the presenting symptoms into the patient's narrative, a task which the patient may not have initiated on her own. Finally, the clinician will make a judgment (or be unable to make sure a judgment) regarding the priority of the biological or the psychological in this particular presentation, and will structure the formulation accordingly… [Phillips: 2005: 182]

If psychiatric diagnosis is, however, to include a narrative based and, as far is possible, idiographic ingredient, if the basic classificatory judgement of psychiatry is to include this element, then what of its validity? Might there not be a tension between these two intellectual aims of recent psychiatry.

Note, first, the contrast with classification in chemistry. There, the validity of the Periodic Table is displayed in classificatory judgements which are essentially general. Samples are described as instances of general types which possess a great deal of 'systematic import', in Hempel's phrase [Hempel 1994: 323]. Validity in chemistry is underpinned by the use of *general* kinds.

The WPA's suggestion pulls in the other direction: narrative components in a comprehensive diagnosis are tailored to individual cases in a way which seems, by definition, to undermine systematic import. Does this undermine the validity of classifications based on this approach? The difficulty in answering the question is that assessing validity seems to require stepping outside one's beliefs to measure them against the world, to check that they line up. But that, of course, is impossible. So it seems that one needs a less direct measure of validity. What is this?

I do not here wish to argue that narrative formulations actually are in tension with the aim of increasing the validity of psychiatric diagnosis: that narrative formulations cannot be valid. But what is clear is that standard models of validity will not apply to them. In a nutshell, standard models of validity are nomothetic whilst narrative formulations are idiographic. It is thus a project for philosophical investigation – informed by empirical work on the kind of diagnoses that are actually made – but one which arises naturally from within self-conscious psychiatry rather than being imposed on psychiatry by philosopher outsiders.

Philosophy as a Set of Investigative Tools

If, however, philosophy is not simply concerned with attempting to debunk or to justify psychiatric practice from outside, and if the philosophical work that is continuous with and relevant to psychiatry has been carried out by psychiatrists as well as by professional philosophers, how should it be best understood? What kind of thing is the philosophy of psychiatry? Where does it fit with psychiatric practice? I think that the most promising approach is to take philosophy of psychiatry to be less a body of results or theories evolved over the last hundred, three hundred or two thousand years (depending on one's perspective) and more a set of tools and abilities for analysis.

Note first that the philosophy of psychiatry is not akin to a 'natural kind'. There is not an established set of closely interrelated problems with familiar, if rival, solutions. It is not like philosophy of mind or epistemology which have achieved the status of Kuhnian normal science with a settled role within the academic philosophy syllabus [Kuhn 1998]. Published work in philosophy of psychiatry is much more heterogeneous. It is generally drawn from different parent sub-disciplines within philosophy - such as philosophy of mind, philosophy of science and ethics - in response to specific issues or phenomena raised by or within mental health care. The range of issues covered – eg by the recent OUP series *International Perspectives in Philosophy and Psychiatry* – is great and without a single common ingredient or focus.

Secondly, unlike some areas of philosophy, philosophy of psychiatry can have a genuine impact on practice. It is a philosophy of, and for, mental health care, providing tools for critical understanding of contemporary practices, of the assumptions on which mental health care more broadly, and psychiatry more narrowly, are based. Thus it is not merely an abstract area of thought and research, of interest only to academics and insulated from everyday concerns. In providing a deeper, clearer understanding of the concepts, principles and values inherent in everyday thinking about mental health, psychiatric diagnoses and the theoretical drivers of mental health policy, it can impact directly on the lives of people involved in all aspects of mental health care.

This suggests that philosophy of psychiatry is best understood as a set tools and techniques to aid analysis and investigation. It is that rather than a set of established theories and results. Of course, there are philosophical theories or models that are relevant to psychiatry. Three centuries of discussing the relationship of mind and body have furnished philosophers with a variety of subtle models (from forms of dualism, through gradations of physicalism, to eliminativism with modern alternatives such as enactivism) which can help in the

interpretation of psychiatric data. Equally, substantial ethical theories have informed both medical and psychiatric ethics. But whereas in some areas of philosophy both the problems and their attempted solution seem to be specifically philosophical, isolated from the concerns of everyday life (cf. the relation of radical scepticism to everyday practical certainties), that is not and should not be so for philosophy of psychiatry. Substantial theories have a role within philosophy of psychiatry when they are borrowed from their usual more abstract setting to be applied in the analysis of concrete practical issues.

This view also chimes with my own experiences of teaching the subject at masters level (previously at the University of Warwick, shortly at the University of Central Lancashire). The students have mainly come from practice - psychiatry, mental health nursing, social work and the service user movement – rather than from pure philosophy. They choose to work on issues that arise naturally within practice settings and of which they have at least some experience. Thus they might examine the nature of evidence based practice as it applies to talking cures. Or they might look to ethics of the treatment of sufferers from anorexia. Or they might go back to Jaspers to think again about the role of empathy in mental health care but perhaps in response to the established position of criterial DSM style diagnosis.

What such students gain from a masters degree in philosophy and mental health is not so much a snap shot of the present state of debates about evidence, values and the place of mind in nature as applied to psychiatry. Rather, they gain standing abilities to examine and critically analyse conceptual issues that are raised by or underpin psychiatric theory and practice.

If psychiatry itself – and mental health care more generally – were fixed and unchanging, a self conscious understanding of it would be an intellectual virtue, a desirable end where possible. But given the rapid changes in psychiatry in recent years and the continuing outside pressures on it from both public expectation and changing government policy the analytic abilities that make up a self-conscious practice of mental health care are not just desirable, they are necessary.

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There Are No Philosophers in Medical Classrooms Either But There Definitely Should Be

G. Scott Waterman, M.D.

It seems that the intellectual grass is always greener on the other side of campus. As a psychiatrist who generally feels inadequate in comparison to psychologist colleagues when discussing research design and statistical inference, inferior to pharmacologist coworkers when teaching or writing about mechanisms of drug action, and unsophisticated relative to philosopher friends when examining the conceptual peculiarities and contradictions of our field, I found Professor Hansen's insecurity about her "non-psychiatrist status" oddly reassuring. But while misery (or at least self-doubt) clearly does love company, hers is unwarranted. Psychiatry needs philosophy – especially good philosophy – far more than is generally recognized, and is suffering greatly from its near absence in most psychiatric contexts

One reason why this need is largely unrecognized is the remarkable success of neuroscience and the false belief that those advances are being translated into major improvements in the way clinical psychiatrists conceptualize and treat psychiatric illnesses. That naïve view likely underlies the dismissive attitude toward philosophy apparently exhibited by the psychiatrist-cousin of Professor Hansen's student. In addition, though, Professor Hansen appears to have accepted some of the unwarrantedly triumphalist conclusions about contemporary clinical psychiatry now in fashion. She indicates, for example, that Szasz would classify bipolar disorder as a "brain disorder," but do we know the location or nature of the "lesion of cells, tissues, or organs" whose existence must be demonstrated for Szasz to consider it that? She notes that "many psychiatrists are making decisions about treatment without perfect knowledge of what exactly they are treating; they don't always have tests to run or brain scans to interpret." But that is a gross understatement whose implication is that we are far closer than we actually are to having reliable and objective indicators pertinent to psychiatric diagnosis and therapy. She generously assimilates the DSM project to the "biomedical paradigm" and asserts that our byzantine compendium of diagnoses has earned us the respect of other medical specialties, which would be undeserved if it were true. In contrast to some of my colleagues in this organization, I do believe that neuroscience is the foundation upon which a credible and modern psychiatry must and will be constructed. But we are far from achieving that reality, and the obliviousness to that fact of so many psychiatrists is powerful testament to our need for philosophers to help us chart the course from here to there.

The list of questions that we psychiatrists face and with which we need serious help from philosophers is long, and the one I have constructed is undoubtedly incomplete. It does, however, include at least most of the quandaries that I as a

teacher of psychiatry routinely encounter and try, with my students and residents, to address:

- What is the nature of what is meant by 'mental'?
- In what way(s) is what is meant by 'mental' accessible?
- In what way(s) is what is meant by 'mental' causally efficacious?
- What is the relation of the 'mental' to the 'physical'?
- Is there a principled distinction between 'mental' illness and 'physical' illness and, if so, what is it?
- What is the nature of 'causation' in medicine/psychiatry?
- What is the nature of 'explanation' in medicine/psychiatry?
- What are the uses and meanings of taxonomies in medicine/psychiatry and in what ways are diagnostic categories valid or invalid?
- What is the status of the concept of human agency and what are the implications of calling it into question?
- To what extent are intuitive/folk psychological concepts and scientific ones incongruent, and what are the implications of that incongruence?

It goes without saying that the questions listed above represent enormous swaths of philosophical endeavor. In order to delineate more concretely my hopes for a fruitful philosophy-psychiatry collaboration, I have tried to distill into a handful of categories my observations of where medical-psychiatric thinking cries out for philosophical clarification:

1. Stated but belied materialism: It seems uncontroversial that most physicians, including psychiatrists, consider themselves materialists. Why, then, do the biopsychosocial model (which posits a distinction between 'biological' and 'psychological' influences on health and disease) and the DSM multiaxial diagnostic system (which codifies a deep distinction between 'psychiatric' and 'general medical' conditions) enjoy wide acceptance? Why is the organic/functional dichotomy, in its many incarnations in medical discourse, still very much alive in medicine? Do psychiatrists and other physicians not understand the implications of materialism? Are they fundamentally dualists without knowing it? Or is there another explanation?

2. Confusion regarding 'mental' causation and its relation to the 'physical': Even beginning a conversation about this is difficult, as physicians and philosophers literally do not speak the same language. Thus, while pain is in the philosophical literature the quintessential 'mental' (i.e., subjective or private) phenomenon, in medicine it is considered a "physical symptom" – an oxymoron, given the definition of 'symptom' as subjective and thus not 'physical' in the sense of public or observable. This fundamental confusion underlies the current practice of mislabeling the use of psychotherapeutic techniques in the treatment of pain as "mind-body medicine." Beyond this considerable semantic problem, physicians' (including psychiatrists') beliefs about the 'mental' being causally efficacious seem at once disparaging and exalted. According to a press release from my institution, the finding of abnormal serotonin signaling in irritable bowel syndrome (IBS) "lends credibility to the notion that IBS is not simply a psychological or social disorder as was once thought." On this view, a "psychological disorder" is apparently one for which there simply is no causal mechanism. But while my local gastroenterology friends believe that they saved IBS from the ignominy of having a "psychological" etiology, the invocation of such causal factors is a universal gambit in medicine when all efforts at "medical" explanation (whatever that means) fail – thus investing the 'mental' with what amounts to magical powers. If the solution to this problem is the doctrine that mental states are physical states, does that warrant Professor Hansen's statement that "talk of mental states" would thereby be rendered "meaningless"? Does, in similar fashion, the identity relation between heat and mean molecular kinetic energy render talk of hot and cold meaningless?

3. Confusion of description with causation or explanation: Physicians are used to thinking of diagnosis as being closely related to causation and explanation. Thus, there is a sense in which saying that a patient has pneumonia *explains* why his chest hurts when he inspires, and a sense in which the infection *causes* the pain. But what about purely syndromal diagnoses? Is someone's difficulty with organization *explained* by her having attention-deficit disorder? Is her discomfort around other people *caused* by her social anxiety disorder? And what potentially useful explanatory efforts are being forsaken if these are taken as genuine? Do we want our students and colleagues to believe this is the best we can do and that mechanistic accounts of these phenomena should not be sought?

4. Problems with the prevailing diagnostic system: Although supporters of the DSM project purport – to greater or lesser extents – that the diagnostic system is etiologically agnostic, based on objective (i.e., observable) criteria, and consistent with practice in other medical disciplines, is there reason to suspect that any of those claims are true? I have already alluded to the dualism inherent in the separation of Axes I and II on the one hand from Axis III on the other. Is there any sound conceptual or empiric basis for the separation of Axes I and II? Are the ubiquitous arguments among psychiatrists and psychiatric trainees about whether, for example, an emotionally unstable patient "really has" bipolar disorder or instead has "an Axis II problem" actually *about* anything? If so, what are they about and what sorts of data would count as evidence for one side or the other? And if not, why does an empty question seem so compelling to so many? Claims of etiological indifference notwithstanding, some diagnostic categories clearly carry causal claims. Several of the somatoform disorders demand a role for "psychological factors." What is such a factor and how does one determine whether it exists and is salient in a given instance? And by what mechanism(s) are such factors causally relevant – or does such a question have any meaning in this context, considering that, when invoked by most physicians, a diagnosis of somatoform disorder implies an *absence* of etiopathogenetic mechanism? Is such a thing possible? In that vein, such conditions are commonly held, as an important part of their ontology, to be "medically unexplained." Does that mean "medically unexplain*able*" *in principle*? If so, what renders them so? If not, is the existence of such diagnostic categories merely provisional, pending improved understanding?

5. Incongruence between what seem to be the implications of materialism and assumptions about human agency: Does the fact that most humans most of the time have a strong sense that their actions result from their decisions provide evidence in support of that proposition? Are there compelling explanations for that nearly universal sense, other than its possible validity? Should we cling to pre-scientific notions out of fear of losing our humanity, or should we search for ways by which new knowledge, new understanding, and new insight might enhance our lives? Is there a significant human cost to the intuitive but nonscientific volitional/nonvolitional dichotomy, such as stigmatization of people with addictions or eating disorders? Even if incontrovertible evi-

dence is forthcoming that makes conventional notions of agency and volition untenable, will that affect the way most people see themselves and live their lives?

As anyone who knows me will attest, I have opinions about many of the questions posed above. My objective here, however, is not to express my views about them – though they undoubtedly leaked out in several instances – but is rather to argue that psychiatry desperately needs philosophy to help it ask and then deal effectively and credibly with a range of questions that are both intensely interesting and fundamental to the enterprise in which we are engaged. In fact, I am so convinced that clinical psychiatry cannot afford to leave unaddressed its profound and consequential lack of sophistication in the concepts and methods of philosophy that I favor making such training a requirement in residency training programs. So Professor Hansen should not fret: She is needed – and far more desperately than most of my psychiatric colleagues know or will admit.

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Reaction to Thomas Szasz

Stephen Weiner

As a mentally ill patient living on disability, my experience parallels the philosopher and author's student Samantha whose mother is bipolar. Samantha knows that her mother struggles with real pain and she is so outraged that she can apparently not bring herself to read Szasz to a significant extent.

I have had a similar reaction to Szasz. In 1966 I first started seeing a psychiatrist because of an onset of extreme emotional/mental pain on August 28, 1965 when I was 13 years old. At that time there was a Harper's Magazine article about Szasz in which he laid out his position that psychiatry is a false science and that mental illness does not exist.

Here are a few of the symptoms of mental illness that I have had to endure: a feeling that I would turn into a girl suddenly and against my will; the feeling and simultaneous thought that nothing truly physically existed especially other people with their separate minds; and fear that seeing or touching my mother's menstrual blood would negate the existence of the universe, even though I half believed that the universe didn't exist in the first place. To me, these symptoms are not only real, but if they are not symptoms of a real mental illness, they lock me into a world that is truly horrifying and desperately lonely.

In spite of these symptoms I managed to do well in the last years of high school and graduate from Stanford University with a Bachelor's degree in Communication in 1973. I didn't go on to graduate school but always read voraciously and widely, which I continue to do.

In the course of my readings I found myself physically unable to touch Szasz's most famous book, *The Myth of Mental Illness* for fear that I would be rendered not mentally ill but merely disgusting and evil. However, I read enough excerpts from Szasz' work and commentaries on his work, both pro and con, to be relatively confident that I have understood the gist of his positions.

Following is a quote from Peter Sedgwick's book *Psycho Politics.* I include it here because it expresses exactly my reaction to Szasz.

> Szasz provides neither a convincing paradigm of the psychoanalytic relationship nor even an interior reconstruction of the vicissitudes of the client. His game-playing, behavioural analysis deals only in what the patient does to other people, never in the personal anguish, alienation or stupor which pre-dates the sufferer's communication with others. Mental illness is a language: but it is also the sick one's miserable inability to use a language. It is, to be sure, a social status: but before that, it is a private hell. Szasz attains his role as proxy spokesperson for the rights of the mental patient by ignoring, simply, what it is to be a mental patient.

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It Will Take a Village to Get Philosophers in Foxholes

Peter Zachar, Ph.D.

Jennifer Hansen's essay raises a perennial question about the value of philosophy among both our students and the public, and about the value of interdisciplinary work among our colleagues. Does what we do matter? Obviously, in the *AAPP Bulletin* proclaiming agreement with Jennifer and mounting an additional defense of philosophical problem-solving would be preaching to the choir. I believe, however, that the issue is serious and extends beyond convincing others that philosophy matters. I would, therefore, like to explore some possible responses to its devaluation, and suggest a response option that we all might share.

One typical response that many people have, especially when the dismissal comes from politicians or college administrators, is to point out that American anti-intellectualism is again rearing its ugly head. This response primarily serves cathartic rather than constructive ends. Catharsis can be adaptive, and I don't dispute that anti-intellectualism exists, although I doubt that it is an uniquely American phenomenon. The cathartic response also has the negative consequence of feeding the myth that academics are elitist in a way that other, better paid professions mysteriously escape.

A more constructive response to devaluation and dismissal is to find a secure home base populated by like-minded colleagues. This particular coping strategy is made available by the AAPP. The home base is more secure if it has some status in the larger world, a function served by the Johns Hopkins University press journal PPP and the Oxford University Press International Perspectives in Philosophy and Psychiatry book series.

Another constructive response, the one I want to explore in this commentary, is to train ourselves not to defend *per se*, but to attempt to explain the philosophical issues to those inclined to dismiss them. Jennifer's mentioning the philosophical importance of evolutionary theory is right on target. I agree that the evolution-in-the-schools problem exemplifies the philosopher-hero riding into town on a white horse, helping save the day and proving her or his worth, but as long as evolution has been put on the table I'd like to explore another response to Jennifer's whither philosophy problem. I will do so by focusing on how to respond to the whither evolution problem in a university context.

Assume that the evidence favoring the belief that the universe and all life were created by God in six days was compared to the evidence favoring the scientific theory that the earth is 4.5 billion years old and biological diversity has gradually evolved. Nothing but dogged faith could lead a reasonably intelligent person to choose the strict creationist story in Genesis as being the factually truer account. I take it as well-established that the biblical creation story is empirically false, whereas the evolution of species by means of natural

selection is consistent with more evidence and sound thinking than could be communicated in an article, a book, or even a book series. It is not a matter of believing in evolution, it is an issue of accepting the evidence and its implications.

As a professor at a small university in the southeastern United States, I have learned that many of my students believe that to accept evolution would be to assure their own damnation. They believe this sincerely. They do not think evolution matters to them and they actively dismiss it. The situation in which I find myself vis-à-vis evolution with some of my students is similar to the situation Jennifer describes regarding the philosophical analysis of psychiatry vis-à-vis her students and some psychiatrists. How to respond?

With respect to the students, my job is not to proselytize them, convert them, or win an argument about evolution versus creationism. I know a professor who adopts this kind of approach and it tends to not be very successful. It mostly makes the students defensive. Nor do I adopt a version of relativism which states that I have my view and the students have their views, and there is no way to adjudicate between them. There is a way. The strict creationists are mistaken about the history of life on this planet. All the same, evangelization is not the mission. The mission, to use that term, is to explain to the students as clearly as possible why it is that scientists accept Darwin's theory of evolution by natural selection, and why doing so is important.

This is not an easy task, and requires patience. The information cannot be presented in an hour, a week, or even a semester. Explaining evolution requires careful thinking about the students' various perspectives. For example, in a history of psychology class, describing the medieval debate about faith versus reason and its relationship to the scientific revolution can be very helpful. Descartes and Newton's adoption of Deism as a strategy to make the world safe for science is a radical and new idea to them. They all find it ridiculous that people refused to look into Galileo's telescope because to look and see four moons around Jupiter would be to commit an act of heresy, but then asking them how many people they know refuse to look in the ground and examine the fossil record inevitably results in a few jaws dropping open. All of this is a prologue to explaining natural selection. Helping them be able to see that evolutionary theories make sense (which is the targeted goal) is a process that has to be continually refined semester after semester.

Another important part of this process is engaging student curiosity. John Dewey believed that children are naturally curious and will seek to learn on their own if given the chance. I am not sure about this, or at least, I'm not sure that people tend to be spontaneously curious, especially about academic issues. They can however, become curious, and awakening their curiosity is an important part of explaining evolution. This is an area where I often fall short. I tend to be content-focused and want to get through all the information. It is much better if I occasionally slow down, ask a question or two and try to engage the students so that they actively think about the material. They have to be socialized into this process and it requires some group management skills, but when it works they are more likely to get it. The information does not necessarily change their minds, but they get it.

As I said, there is no way to do it all at once. In the history of psychology class I can situate evolution in the context of the scientific revolution and the development of western society. The students' outright rejection of Islamic fundamentalism helps a bit here. In the biological psychology class, evolution can be presented in the context of geology and genetics. The claim that to categorically reject evolution means you should also reject geology, genetics, paleontology and physics can be made here. Each situation presents its own opportunities.

Furthermore, I've gotten some good ideas from those colleagues in my department who also struggle with these issues. Each of them sees the problem in a slightly different way and each brings different resources to the task of communicating the information in class. Teaching evolution, like teaching other core scientific material in psychology such as statistics and research design is a community responsibility, shared by the whole department (in theory).

I propose that the same attitude I've adopted for teaching evolution can be invoked for communicating why the philosophy of psychiatry should matter to students, colleagues, philosophers, psychiatrists, psychologists and the general public. It is not a matter of engaging them in philosophical debate. It cannot be done all at one time. The presentation of the information has to be practiced and refined over time. It is a community project, not the responsibility of one or two brilliant individuals, and it will be more successful if the curiosity of the target audience can be engaged. I suppose, in some sense, this is how think tanks and invisible colleges operate.

One implication of this project is that the intended audience of an article, chapter or book should not only be the philosophy of psychiatry community. Rather, the audience should be some combination, possibly a shifting combination, of multiple audiences. Reaching multiple audiences, of course, has to always be balanced with the goal of advancing the knowledge base of the discipline.

This recommendation to target multiple audiences raises a complicated issue about interdisciplinary writing. In my experience philosophers have disciplinary preferences and tastes, or using 'standards' talk, they have learned to recognize what counts as a relevant problem and what qualifies as a valid point. Psychiatrists and psychologists might perfectly well understand the words, but they lack the training/socialization to appreciate the 'relevant problem' as more than either trivial or uninteresting.

The same is true vice versa regarding what psychiatrists learn is relevant and what psychologists learn is relevant with respect to the technical problems in their disciplines. Each discipline has implicit background knowledge that its members take for granted and assume, but those implicit cognitive resources are not available to people in other fields. I suspect the same is true for subdisciplines within a larger field. Translation is difficult. I have difficulty even imagining a solution to this problem, but the structure of PPP with a target article and commentaries helps. It is even more complicated communicating to outside the groups. For these reasons alone, making the philosophy of psychiatry relevant is a long term project and a community responsibility.

Let me conclude by examining Jennifer's foxhole metaphor more closely. Even if the base rate is low, by chance alone there will occasionally be a philosopher in a foxhole (or in the trenches), but no one else in the foxhole is likely to think that what the philosopher has to say is very important. They are too busy staying alive. Once everyone is out of their foxholes and behind the lines, however, some people might be more willing to accept that being in a foxhole raises some philosophical issues that deserve scrutiny. It may take effort, patience and time to help them see this. This might lead to a slight increase in the number of philosophers in foxholes, or at least, increase some peo-

ple's appreciation of the various philosophers who willingly place themselves in the vicinity of foxholes.

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Response to Commentaries

Jennifer Hansen, Ph.D.

Before addressing the thoughtful, provocative, and contentious responses to my essay, I want to briefly rehearse how I came to be writing the "target article" for "Philosophy and Psychiatry: Reading and Writing from One Side of the Divide-or the Other." Jim Phillips requested that I share my perspective with the readership of what it is like to be a philosopher interested in teaching, and writing, about philosophical issues emerging out of psychiatry (the field that those of us dedicated to AAPP have called the Philosophy of Psychiatry). He pretty much left it to me to craft this article and so I chose to do some self-reflection on my discipline and then move on to criticize some concerning trends that I see among psychiatrists/ psychiatry. I took on both tasks in order to initiate a discussion that would be fruitful to all of us who are interested in both philosophy and psychiatry and how philosophical tools might inform psychiatry as well as how the discipline of psychiatry forces us to rethink some of our most cherished philosophical views of human nature (i.e. free will). In fact, I really jumped at the chance to write this essay, sensing it was an opportunity for me to reflect on how those of us trained as philosophers approach difficult subject matter in ways that can be upsetting to non-philosophers like my student Samantha. I also wanted to air my frustrations with how many psychiatrists have responded to some of my research and try to unearth the reasons why my interest in the enhancement debates is so off-putting to many psychiatrists.

I spent the first part of my essay acknowledging that the way we are trained in philosophy makes us come across, at times, as insensitive or uncaring even though our interest in questions is quite often fueled by intense passion and commitment. In attempting to get my students to understand the nature of Thomas Szasz's repudiation of psychiatry—how he builds his argument—I *unwittingly* upset her (and perhaps Stephen Weiner, who has submitted his own reaction to Szasz to this Bulletin). Samantha has up close and painful experience of mental illness—her mother suffers from bipolar disorder—and to fathom that anyone would dismiss mental illness as a reality was beyond endurance. My intention, in assigning the reading by Szasz, was certainly not to send a message to any of the students in the class about my own personal views on mental illness. Rather, I wanted to familiarize them with one of the towering figures out there, with a great deal of supporters, who attacks the very legitimacy of psychiatry, and then get down and really analyze how sound his claims were. Szasz is also clearly a pivotal figure in the history of psychiatry, precisely because he motivated the taxonomic discussions and work groups that resulted in the DSM-III and Jerome Wakefield's "Harmful Dysfunction" model.

Alas, I unwittingly angered Samantha and in a way that really gave me pause to think about what I am doing when I am teaching philosophy that can lead to such harm (let's remember philosophers have been not well loved for centuries—Socrates anyone?). I believe that any philosopher who embarks on teaching such a class must be mindful of the fact that while we may try to approach much of the material as 'academics'—that is impartial, neutral, and distant—we will find our classrooms filled with students who are either battling mental illness or know loved ones who are. Striking a balance between academic integrity and being a compassionate human being is hard enough for a college professor without the added burden that students may be enrolling in your course precisely because they are trying to sort out their experiences will mental illness and are looking for more therapy and reassurance than information. Hence, my interaction with Samantha lead me to get honest about how philosophers present information or frame debates that can make both psychiatrists and patients suspicious of our motives. I wrote:

> . . .by virtue of our discipline, we are moving from the messiness of the tragic particulars to the general and abstract; we are often removing questions from the context of the practitioner making life or death decisions in his office, to the more serene halls of academic conferences or classrooms. I wonder, at times, if some of the real offense we cause is rooted precisely in our turning real people and real tragedies into 'what if' questions?

So here I was, making myself vulnerable to a bunch of psychiatrists, who very well might distrust me or other philosophers for this manner of approaching philosophical questions arising out of psychiatry, such as the reality of mental illness. I dared to do so in order to admit that this might be worthy of criticism and then went on to try and find what is still worthwhile in the philosophical endeavor despite this *apparent* cold, inhumanity in the face of tragedy.

Unfortunately, spilling my guts had the unfortunate result of inviting David Brendel to further flog me for my admitted shortcomings, to add some more indictments of my character, and then tell me that I was wasting my "talent" on pseudo-questions that were of no real interest to clinicians. Brendel accuses me of being "dismissive and highbrow" and failing to listen to Samantha and then goes on to critique my pedagogy and research interests. With such a response, I proceed forthwith with great trepidation. While I may have upset Samantha in ways that I could have avoided if I would have followed the fine example of fellow philosophers such as Christian Perring and Nancy Potter—who have both spent time shadowing psychiatrists and even incorporating such activities into the classroom (ideas, that I do desperately want to adopt!)—I think it is an unfortunate reading (*listening to?)* of my essay to infer that I had not properly listened to, cared about, or reflected on what Samantha or any of my students had to say.

It is precisely because I listen to my students, Samantha included, that I have formed the peculiar research interests that I do. For example, my interest in the enhancement debates that were brought to life by Peter Kramer's work intrigue me precisely because I have so many students confess to me their rampant use (or misuse?) of ADHD drugs on campus, such as Ritalin (see Kadison 2005). The students brag about how easy it is to get a prescription or to buy these drugs off of their fellow classmates. Many of them have genuinely improved their grades because they can stay up all night and study for chemistry examinations (I have many pre-med students). Recently, I shared these stories with my father, who is a gastroenterologist, and asked him how pre-med students coped before ADHD diagnoses. I expected he would tell me about study

groups or mandatory study halls. Instead he told me about Dexedrine; he said that almost everyone he knew maintained the insane work pace that the pre-med curriculum imposed by buying Dexedrine. Times haven't changed much, except that students seek out ADHD, anti-anxiety, and antidepressant prescriptions and get their insurance companies to cover the cost of these study aids (see also Harmon 2005). Richard Kardison, Chief of Mental Health at the University Health Services at Harvard University, writes:

> Unfortunately, beyond legitimate prescription medications lies new territory marked by illegitimate, or at least inappropriate, uses of stimulants and antidepressants—practices that are often not even covert. Increasing numbers of students and sometimes their families, request medication to provide an 'edge,' even if the students have no clinically significant impairment of functioning. They think of such drugs as safe 'brain steroids' that help to maximize performance with minimal risk, and they know the symptoms to describe in order to persuade a doctor to write a prescription (2005, 1089).

This reality—the one in which I am immersed as a college professor at an elite liberal arts college—is what guides my research. And, I can attest to how popular these sorts of moral questions are with students who are witnessing the use and abuse of psychopharmacological drugs..

I am still surprised that when I share my interest in these ethical debates and how much they tie into larger, metaphysical questions about free will implied in the neuroscientific turn in psychiatry that I am told by psychiatrists that these are not the really important, interesting, or useful questions. Mark Rego has consistently maintained the position that there is no scientific support for the existence of 'mood brighteners' and furthermore that many task forces have finally settled the issue of whether or not mental illnesses are categorical rather than dimensional. In his view, mental illnesses diagnoses simply do not include normative experience. The problem with philosophers tackling questions such as the over inclusiveness of mental illness diagnoses or patients seeking enhancement drugs is that "there is an overabundance of reason alone and a surprising lack of awareness of pertinent research." This rather sweeping condemnation of philosophers hardly seems supported by his anecdotal examples of articles in PPP not citing the relevant research on Minimal Cognitive Impairment. For example, on the debate over categorical vs. dimensional models, Zachar and Kendler (2007) argue: "Our intuition is that although certain psychiatric disorders may turn out to be discrete categories, this will be the exception and not the rule. For example, one of us failed to find discrete boundaries around the psychiatric disorder of major depression" (563). Furthermore, Kendell and Jablensky (2003) make clear that psychiatrists need to be cautious when considering that mental illness diagnoses are valid. "[I]t is important to distinguish between the validity and the utility," write Kendell and Jablensky, "of all diagnostic concepts and of their formal definitions. Otherwise, the term 'valid' will continue to mislead, implying some kind of scientific respectability but actually meaning little more than 'useful' " (11).

Moreover, the character of responses to my interest in the enhancement debates by Brendel, Rego and Heinrichs—focusing on the preposterousness of 'mood brighteners'—suggests to me that none of them has actually read Peter Kramer's work (perhaps the media hype that surrounded it?). Surely, Kramer does not argue that Prozac is a 'mood brightener,' nor does he think that SSRI drugs are 'happy pills.' What he details is the way in which Prozac makes many of his female patients less sensitive to perceived or imagined rejection and therefore more likely to exhibit personality traits that are more socially rewarded. Women are bombarded by that very message from pharmaceutical advertisements, which suggest they can better adjust to the demands of the workforce, without sacrificing their nurturing, maternal self. The number of women prescribed SSRI drugs since the FDA relaxed its rules on advertisements for pharmaceuticals has jumped dramatically (Burt and Bernstein 2003). While the clinicians in these pages may not be among those who are prescribing SSRI drugs to stressed out mothers—trying to balance unrealistic work and family demands—clearly there are physicians out there who do. It is far from clear that what they are treating, when prescribing these medications is a valid disease, but rather the effects of damaging social trends. Kramer's interesting question is: so what? If giving pills to women, who do not quite meet the DSM-IV criteria for major (or even minor) depression, helps them cope with social forces too massive for any one woman to surmount and enables them to be more successful, resilient, and effective in their professional career—hasn't an important medical service been provided? Is this necessarily unethical? And if so, why is it unethical? This might not be a question that preoccupies all clinicians, but certainly Heinrichs, Brendel and Rego don't speak for all psychiatrists do they? Otherwise, we wouldn't see such a robust literature emerging on the bioethical implications of enhancement.

David Brendel and Douglas Heinrichs both argue that the best and perhaps only way that philosophers can really be of service to clinicians is if they focus on ethical questions emerging out of the physician-patient relationship. Douglas Heinrichs, for example, argues "that the proper range of discussions about psychiatric theory has to do with which, of the interventions we can do, we should do with an given patient, and what principles should guide those decisions." David Brendel, in a more patronizing tone, writes "if academic philosophers like Hansen expect to be part of the debate about what is really going on in psychiatry today, then they need to be less preoccupied with such far-fetched scenarios [enhancement] and instead roll up their sleeves and engage in the messy problems that patients and psychiatrists are currently facing." Heinrichs also adds that my interest in enhancement ultimately has nothing to do with psychiatry; rather, it is a question that bubbles up out of the abstract theory of neuroscience, hence I have wrongly conflated psychiatry with neuroscience. I disagree that you can disentangle the metaphysical questions emerging out of neuroscience from clinical psychiatry—a view that happily G. Scott Waterman shares. I also disagree that the only way that philosophers can be useful to psychiatrists is to focus on the ethical decisions that emerge out of the patient-psychiatrist interaction. I do think these are important questions, and that many philosophers will happily pursue them, but it is just wrongheaded to insinuate that philosophers drop all other questions—whether they be on the philosophy of mind, phenomenology, or speculative debates on enhancement because such work is not immediately useful for clinicians.

Philosophy is not a handmaiden to psychiatry. Nor is it, as Tim Thornton astutely reminds me, the "queen of the sciences." Thornton writes: "it is a mis-

take to think that philosophy is primarily either for, or against, psychiatry. The reality is more complex but also much more interesting and useful than that. *Philosophical questions arise naturally within psychiatric theorizing. Philosophy is thus continuous with self conscious psychiatry*." Here I think Thornton is getting back to the spirit of Phillips' conception of this Bulletin issue: how do the fields of psychiatry and philosophy inform each other? The point is not to figure out how a philosopher like me can either serve as an "external legislator" to psychiatry, nor how I can refocus my philosophical training and skills, roll up my sleeves and get messy with psychiatrists. Rather, the larger question here is whether or not there can be a fruitful relationship between the two disciplines. This has always been my hope, which is why I seized the opportunity to reflect on why the relationship isn't always as happy as it might be.

Let me end my comments by pointing out what I think all of us, who have contributed to this issue share: a belief that philosophy should serve life. None of the commentators here seems interested in pursuing the abstract, philosophy-for-the-sake of philosophy questions; all of us seem interested in how the relationship between our disciplines will either improve our understanding of human nature or improve the practice of psychiatry. We seem to diverge, however, on how to best forge the relationship between philosophy and psychiatry. I am heartened by the contributions by Peter Zachar, John Sadler and G. Scott Waterman, who are all rather sanguine about the relationship between our disciplines. Waterman goes so far as to argue: "psychiatry desperately needs philosophy to help it ask and then deal effectively and credibly with a range of questions that are both intensely interesting and fundamental to the enterprise we are engaged in." Sadler writes: "We need courses like Professor Hansen's to develop new citizens who care about mental illness and the ill, and want to promote a humane, thoughtful psychiatry. Samantha, take that psychiatrist on. Hold him/her accountable. Be skeptical, be tough-minded, be caring." And Zachar takes cues from his difficult task of teaching evolution in the bible belt to find ways in which philosophers and psychiatrists might better communicate with each other by rethinking the audiences that we want to engage in our writings and how to successfully *translate* our ideas in ways that coincide with the background assumptions of both disciplines. The work of translating and communicating what we are both up to is enormous, as evidenced by the responses to my essay, but what Zachar suggests, that I find very attractive, is that we take this on as a "long term project" and "a community responsibility." Hopefully this Bulletin issue is one of many first steps in building the community that will "attempt to explain the philosophical issues to those inclined to dismiss them."

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sure that PPP articles are neither clinically or philosophically naive. A key part of this latter mission is the nurturing supplied by the reviewer-educator. Balance and depth in clinical and philosophical viewpoints is an ongoing challenge for PPP, requiring ongoing vigilance.

All of this is just a way of saying thank you for responding so well to a demanding task, building the cross-discipline of philosophy of psychiatry. If you have been a reviewer for PPP, thank you and please continue, and don't forget your task as an educator. If you would like to be a reviewer for the journal, please e-mail me with your interests and expertise. We are still expanding the circle.

John Sadler, M.D.

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We are doing philosophy of psychiatry, not psychiatry of philosophy (or, to make it sound less clinical, psychiatric contributions to philosophy). Of interest, the editorial statement in PPP states: "Philosophy, Psychiatry, & Psychology (PPP) focuses on the area of overlap between philosophy and abnormal psychology and psychiatry. PPP seeks to: (a) enhance the effectiveness of psychiatrists, clinical psychologists, and other mental health care workers as practitioners, teachers, and researchers by illuminating the philosophical issues embedded in these activities; and (b) advance philosophical theory by making the phenomena of psychiatry and clinical psychology more accessible to philosophers." And the PPP directive for manuscript reviewers states: "The main aim of PPP is to encourage new research in the area of overlap between philosophy and ***abnormal*** psychology and psychiatry." Indeed, although the content of PPP (and the IPPP book series) shows a tendency toward the philosophy of psychiatry, it also shows a mix of the philosophy/psychiatry interface moving in both directions. Thomas Fuchs' (June 2005) "Corporealized and Disembodied Mind: A Phenomenological View of the Body in Melancholia and Schizophrenia" is a exercise in philosophy of psychiatry. In contrast, the March 2005 issue, edited by Grant Gillett and Douglas McConnell, is an exercise in the use of psychiatric/psychoanalytic concepts to further philosophical reflection.

I do not want to suggest that we should stop doing philosophy of psychiatry. These commentaries demonstrate what a rich field of endeavor that is; and as one of the above citations indicates, in psychiatry we need all the help we can get. I wish only to question what has happened to the other half of the mission statement. Do psychiatry and abnormal psychology not give philosophers plenty

to chew on? In this symposium the primary example of that second kind of questioning is offered in the target article itself. But why the petulant response to Hansen when she engages in philosophical speculation stimulated by psychiatric phenomena? Why *not* speculate about the implications of enhancement drugs, which will surely be available in our future (as opposed to getting tied up in Peter Kramer's unfortunate overstatement that they were already available in antidepressants)? And why not applaud Hansen when she speculates as follows: "If neuroscience proves to unearth the countless mysteries of human agency, personality and mental illness, then we, as philosophers, must point out that the implications for our most cherished notions: responsibility, free will, and choice will be nothing but "folk psychology," reminding us of our once scientific infancy. The promise of neuroscience threatens to dehumanize us. Carol Freedman succinctly argues '. . . what is at stake is a conception of ourselves as responsible agents, not machines.' While clinicians are hard pressed to see their work as reengineering the human race through psychotropic drugs, philosophers can't help but ask basic questions about what it would mean to no longer treat human beings as able to give reasons for their behavior, to interpret their behavior, and thereby empower themselves to transcend the forces acting on them. If human agency comes in tablet form, then, indeed, we will no longer be selves."

The citation from Pascal at the beginning of this commentary is preceded by the following statements:

> #412. There is internal war in man between reason and the passions.
> If he had only reason without passions...
> If he had only passions without reason...
> But having both, he cannot be without strife, being unable to be at peace with the one without being at war with the other. Thus he is always divided against and opposed to himself.
>
> #413. This internal war of reason against the passions has made a division of those who would have peace into two sects. The first would renounce their passions and become gods; the others would renounce reason and become brute beasts. (Des Barreaux.) But neither can do so, and reason still remains, to condemn the vileness and injustice of the passions and to trouble the repose of those who abandon themselves to them; and the passions keep always alive in those who would renounce them.

We no longer divide ourselves so neatly into reason and passion. But Pascal's further statements do provide a context for his aphorism on the intertwining of sanity and madness. And allowing for a not-so-difficult translation of his reason and passion into contemporary terminology, his aphorism seems anything but dated. I am reminded here of Harry Stack Sullivan's own aphorism, reflecting on his intensive work with schizophrenics, that we are all more human than otherwise. Yes, we do make our distinctions between the mentally ill and the not mentally ill. But yes, it is not always that clean, and here surely is grist for philosophical reflection.

James Phillips, M.D.

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