AAPP Association for the Advancement of Philosophy and Psychiatry

Bulletin

Volume18, Number 1 **2011**

From the Editor

This issue of the Bulletin is a potpourri of offerings. First, there is Michael Schwartz's tribute to Al Freedman on the occasion of Al's recent death. We had named Al as the first Life Fellow of AAPP a couple years ago on the occasion of his declining health and inability to remain active in the organization (the declining health did not prevent him from writing letters to the NY Times to argue for his strongly felt causes).

To accompany the tribute Michael provided us with a photograph from the AAPP Executive Council meeting held at his house in Westport, CT in 1990. This meeting was my first contact with the developing AAPP group, as well as our first meeting with Bill Fulford, who was in the process of forming the Royal Society philosophy of psychiatry inter-

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Tribute to Alfred Freedman

Al Freedman, a Founding Member of AAPP's Executive Council and our First Life Fellow, died of complications from surgery for repair of a broken hip in New York's Mount Sinai Hospital on April 17, 2011. He was 94 years old.

Al, a psychiatrist of international renown, joined AAPP shortly after our association was conceived following a successful panel presentation at the 1989 American Psychiatric Association's annual meeting in San Francisco. Subsequent to this meeting, Ned Wallace invited a small group of us[1] to Augusta, Georgia to strategize about the development of a philosophy and psychiatry organization.

A follow-up meeting – the launch meeting of AAPP – was scheduled at my home in Westport, Connecticut. But how could we draw in a wider group? How could we develop a viable structure? Launch a journal? Go international? Draw in the luminaries of the field? Who better to ask than Al Freedman – my Departmental Chairman at the time, a psychiatrist deeply interested in the big issues in psychiatry, and a man of exceptional experience and accomplishment. Al and I met for lunch at the faculty club at Cornell Medical College in Manhattan. As we dined, he provided guidance, direction and strategic advice and accepted a place in AAPP's future Executive Council. A Past President of the American Psychiatric Association (APA), Al straightaway connected me with APA's then Medical Director, Mel Sabshin, and before the day was done AAPP was on its way to its cur-

(Continued on page 2)

AAPP Executive Committee Meeting, 1990, at Michael Schwartz's house in Westport, CT
(from left: Jim Phillips, Al Freedman, Manfred Spitzer, Paul McHugh, Michael Schwartz, Jerry Kroll, George Agich, Phil Slavney, Ozzie Wiggins, John Sadler, Bill Fulford)

(Continued from page 1, Tribute)
rent status as an APA "Allied Professional Society." We had "cache" – we were strategically invited to have our AAPP Annual meeting at the time and site of APA's - and we have so met for more than the past 20 years.

Al can be seen a short time later, at the left end in the first row, in a photo taken on my patio in Westport, Connecticut during AAPP's first Executive Council meeting in 1990.

Dr. Alfred M. Freedman, AAPP's first Life Fellow, graduated from Cornell and the University of Minnesota School of Medicine and began his Residency in Psychiatry at Belleview in 1948. His impact on Psychiatry, and indeed on American culture, would be large. He served as Chair of the Department of Psychiatry at New York Medical College, co-created the *Comprehensive Textbook of Psychiatry*, and created and led the journal *Integrative Psychiatry*. *The International Society of Political Psychology* has an annual Alfred M. Freedman Award honoring his contributions to that group. Al was a Past-President of the American Psychopathological Association (1971-2) and of the American Psychiatric Association (1972-3).

Al's term of leadership in the American Psychiatric Association merits further description. Prior to Dr. Freedman, APA Presidents ran unopposed in an organization that could well be described as an "old boys network." In this setting, Al was the first to petition his way on to the ballot and into office. And, as President during a time of social upheaval, he played a critical role in APA's removal of homosexuality from the list of psychiatric disorders and in APA's declaration that homosexuality was no longer to be stigmatized by psychiatrists as a mental illness. This action has been properly regarded as one of the 100 most important US achievements in the 20th century. Al's Presidency of APA was also the time of Viet Nam, and the stealing of medical records from of the office of Daniel Ellsberg's psychiatrist by the Watergate burglars occurred during Al's tenure.

Subsequently, Al's passionate and powerful commitment to medical privacy led to his constituting and leading the broad and effective National Council on the Confidentiality of Medical Records and the consequent reform and improvement of medical privacy laws.

Al was a lifelong human rights activist, ceaselessly and effectively campaigning for the rights of all but especially of those whose human rights have been violated. Concerned about the care and education of underserved children, he participated in the development of Project Head Start. During his term as Chair of New York MedicaL College, then based in East Harlem, he established a narcotics treatment program as well as psychiatric wards at the Metropolitan Hospital. His advocacy for human rights during his tenure as APA President is described above. Subsequently, exposing systematic abusive psychiatric practices in the Soviet Union, he led an international delegation to a Soviet meeting of the World Psychiatric Association which resulted in a withdrawal of the Soviets from WPA from 1983 until improvements were documented in 1989. In recent years, Al Freedman continued effective campaigning against psychiatric abuse in the interrogation of prisoners and against any role for psychiatrists in executions. In 2008, 60 years after beginning as a Psychiatrist, Al Freedman was named as the recipient of the Human Rights Award of the American Psychiatric Association.

What a privilege for all of us in Association for the Advancement of Philosophy and Psychiatry to have been mentored and guided by Alfred Freedman.

Endnote

1. John Sadler, Michael Schwartz, Manfred Spitzer, Osborne Wiggins

Michael Schwartz, M.D.

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AAPP Annual Meeting 2012

The Biopsychosocial and Other Models for Psychiatry: Philosophical Perspectives

May 5 & 6, 2012
Philadelphia, PA

(in conjunction with the American Psychiatric Association Annual Meeting. Conference Co-Chairs: Christian Perring, Ph.D., Dowling College, and James Phillips, M.D., Yale University)

In 1980 George Engel formulated the biopsychosocial model to account for the missing dimensions of the prevailing biomedical model. Presented as a model for both medicine and psychiatry, the BPS has had an uneven course over the ensuing decades, defended as the best model for a multifactorial approach to psychopathology, criticized for being general and obvious to the point of saying nothing.

The AAPP Annual Meeting will address the status and viability of the BPS model, as well as questions regarding competing and potentially more theoretically sound alternative models

Possible relevant topics for consideration at the meeting include: What is a "model" of psychiatry, and what are the necessary properties of an adequate model? What are the metaphysical assumptions of biopsychosocial, biomedical, or other models? The DSM claims to be atheoretical: is there an implicit model—biopsychosocial, biomedical, other—in the DSM? Does a model of psychiatry illuminate debates between holism and reductionism? Does the debate between different models involve the mind/body problem.

The AAPP invites authors to submit abstracts of proposed papers dealing with these or related subjects. **Abstracts should be 500-600 words in length and should be sent via e-mail before November 15, 2007 to the program chairs, Christian Perring, PhD, (cperring@yahoo.com) and James Phillips, MD (james.phillips @yale.edu) Notices of acceptance or rejection will be distributed in early January.**

The Association for the Advancement of Philosophy and Psychiatry

MINUTES

FALL 1990 MEETING
OF THE EXECUTIVE COUNCIL OF THE ASSOCIATION
FOR THE ADVANCEMENT OF PHILOSOPHY AND PSYCHIATRY
(Formerly Group for the Advancement of Philosophy and Psychiatry)

Present: Schwartz, Freedman, Spitzer, Wiggins, Slavney, Sadler, Agich, McHugh, Knoll
Guests: K.W.M. Fulford, Tony O'Connell, Jim Phillips

Friday, November 2, 1990

1. Dr. Schwartz called the meeting to order at 2:00 p.m.. Dr. Schwartz lamented Dr. Wallace's absence.

2. The agenda for the meeting was discussed.

3. Dr. Slavney introduced the concern of the size of the group, and the scope of the endeavor. Dr. Schwartz introduced the idea of fellowship/membership and with an overarching Executive Council (as noted in his draft of the Constitution). Wiggins feels that quality must be preserved as the overarching guide organizationally. Dr. Agich thinks the quality may not necessarily be protected by organizational structure per se. Dr. Fulford felt the "sleepy" members actually help make an impact on the field, or turn out to assume quality leadership roles. Dr. Freedman feels the organization should be freestanding, thinks that a thematic approach to annual activities would be a good building strategy. He feels that membership should be open to fellowship to all, depending on accomplishment over time. Dr. Fulford is concerned such an approach would limit impact on the APA. Fr. Freedman felt that APA programs would facilitate the "grassroots" appeal. Dr. McHugh voiced concern over the development of factionalism especially with a more democratic approach in the early phases. We should proceed with the group activities only under the goal of facilitating progress in the larger field. We also need collegial help from others for the betterment of the intellectual work. Dr. Sadler felt that the group to be influential in the field must have strong leadership. Dr. Slavney wanted to de-emphasize the importance of any political agenda and instead focus on personal enhancement, and making an intellectually stimulating group.

4. Dr. Sadler suggested that the group review and append the draft Constitution as a way of shaping the discussion. The group proceeded with this.

5. Dr. Agich discussed as a representative philosopher that this notion of fellowship is foreign, even offensive. Dr. Freedman asked "What do we want members for?" There was much discussion about the extremes of being a professional/guild organization vs. an interest organization. Dr. Schwartz emphasized the difference in professional roles with psychiatrists and philosophers. Agich: How seriously do we want to reach out to philosophers? Slavney: This was a group largely founded by psychiatrists that reaches out to philosophers. Dr. Freedman pointed out that fellowship is common in psychiatric organizations. Wiggins suggested that the criteria be explicit for promotion from member to fellow. He also feels that the problem with philosophers operating independently in the group would be the lack of knowledge of psychiatry. HcHugh and Freedman thought that the criteria could be left to a membership committee and the details worked out later.

6. Fellows should be voted on through the mail, and appropriate materials for review be supplied by current fellows. Perhaps a paper should be presented as well.

7. McHugh: The aim of the organization is to enhance the recognition and consideration of philosophical problems in psychiatry to the betterment of the field. McHugh suggested that the focus should be on the identification and explanation of psychiatric disorders.

8. Tony O'Connell, editor of the Comprehensive Psychiatry journal, discussed his view on the importance of this group and its inquiries, and sat in on our work on the Constitution.

9. The meeting adjourned for a break to reconvene at the Red Barn at 7:00 for Dr. Fulford's talk and dinner.

Saturday, November 3, 1990

1. Dr. Schwartz called the meeting to order at 10:45 a.m.

2. Dr. Schwartz introduced Manfred Spitzer's talk on the state of philosophy and psychiatry in Germany, historically and currently. Manfred's talk generated a lot of discussion.

3. Dr. Fulford passed out a copy of the British group's newsletter. He informed us of the European Society of Philosophy of Medicine and Health Care meeting, and a potential for presentation. Interested parties should contact Dr. Fulford. He also raised the issue of discussing the international group development through the Mission Statement. He would like to pull the international group together next June 1991 in Oxford. Dr. Freedman asked about delegates vs. membership. Fulford sees it as both—a delegate committee for each group. Dr. Sadler raised the issue of funding for travel—none available. Dr. Schwartz stated that there may be some drug company support, as well as foundation support for the activities.

4. The international group should facilitate quality work in this area as well. International group should have practical goals: journal, opportunities to work in other countries, revising/improving the Philosophers Index for our use. Pre-established time periods should be set for achieving these goals. There could be a review at the end of five years.

5. McHugh stressed that psychiatry is changing in our direction. He sees us as doing the basic methodology for the 90's psychiatry. We should be looking for the big funding sources. We can catalyze the movement. Fulford would like to see opportunities for research in this area.

6. We had a brief break, and then returned to discuss the mission statement.

7. We discussed how to proceed. The Mission Statement was seen to be practically two things. One would be a short document to describe what the Association is about. Another would be an article that is intended to foment change within the larger profession.

8. There is a press to take care of certain administrative tasks. We must have an administrative structure but not necessarily a group of holders of posts.

   Tasks could include:

   - incorporation issue (Schwartz)
   - finish Constitution (Schwartz)
   - journal (Sadler, Agich, Schwartz, Slavney)
   - program in May (Sadler)
   - membership issues (deal with in May)
   - dues/treasury (Sadler)
   - program in June (Schwartz)
   - brochure (Sadler, Agich)
   - bibliography (Kroll)
   - mission statement (completed this meeting)
   - newsletter (Phillips)
   - summer education meeting at resort (Mchugh)

9. The May Program: Sunday will have 2 invited papers and 1 refereed paper each morning and afternoon, with commentary on each session. On program do not differentiate invited from submitted papers.

10. Papers submitted in May may be submitted for the June meeting.

11. Brochure—Dr. Sadler and Ms. Muncy can compose and distribute the brochure. Dr. Agich will compose the text, help with the layout, and collaborate with Dr. Schwartz with the details.

12. Newsletter—It should come out later when we are organized and things are happening. It could incorporate an abstract service on a limited basis. It could currently describe movement of the group.

13. Set Dues in May—$25-75 fellows and members, $10 residents, $5 students. We need more information about costs until a membership drive with dues can be made.

14. Jerry—will start to collect a bibliography.

15. Mission Statement—What do we want in it—whaat do we mean by it? (see draft text)

16. Future topics for AAPP meetings: relationship between philosophical theory and psychiatric theory (from Wiggins).

17. The draft of the Constitution was left to Dr. Schwartz to complete after legal consultation. Dr. Sadler will assist in distributing. The Mission Statement was largely completed. It will be incorporated into GAPP/AAPP mailing materials by Dr. Sadler.

Sunday, November 4, 1990

1. The Constitution's goals were revised.

2. McHugh suggested as a member benefit an educational meeting at a nice resort each year—he was willing to be in change of this for summer 1992.

3. The Council thanked Michael, Joan, Helen, and Angela for the extraordinary comfort and welcome they provided, and the meeting adjourned.

Respectfully submitted,

John Z. Sadler, M.D.
11/5/90

Review

Philosophy of Psychiatry: A Companion, Jennifer Radden (ed). Oxford University Press, 2004.

Claire Pouncey, MD, PhD

In *The Philosophy of Psychiatry: A Companion* Jennifer Radden has taken on an enormous challenge, and in succeeding has provided an equally large contribution to this interdisciplinary field. Following in the footsteps of its older sibling, bioethics, it has taken twenty years of groundbreaking work by some extraordinary scholars in order for the philosophy of psychiatry to establish itself as a discipline in its own right. As was the case with bioethics, philosophers tend to be slow to embrace "applied" inquiries as "real" philosophy, and medicine is slow to welcome the input of non-physicians into the medical domain. However, there is no denying that both philosophy and psychiatry characterize and manipulate the abstract: to my mind, it was inevitable that each discipline's abstractions would eventually mutually engage the other. This book illustrates this mutuality well.

Philosophy of Psychiatry is an edited volume with two ambitious and crucially important goals. First, Radden establishes the legitimacy of this field as an area of scholarly work. Second, she and her authors demonstrate how interdisciplinary work can proceed. In Radden's introduction, she historically situates philosophy of psychiatry amid strong influences from philosophy, public policy, and psychiatric theory. She describes the book as an explicit attempt to "emphasize the interconnections between these separate [theoretical and practical] inquiries and the coherence of the philosophy of psychiatry conceived as a single body of research" (p. 7). By allowing her authors to pursue traditional questions in new ways, and to introduce new questions for consideration, Radden's book functions something like a birth announcement for the philosophy of psychiatry as a unified, if variegated, discipline. The essays in this book thoughtfully challenge standing assumptions in both philosophy and psychiatry by demonstrating that when the philosopher trains her eye on the world, the traditional boundaries between metaphysics, epistemology, value theory, and logic seem less fixed than we often suppose them to be.

The book is organized around five overarching themes, all of which explore the inherent tension between psychiatry's quest for objectivity and the personal nature of psychiatric problems. The book's five sections, each with several essays, explore these themes: (1) the grounds on which we distinguish pathological and normal experiences and behaviors; (2) the conceptual tensions that co-exist within psychiatric theory; (3) questions about how psychopathological theory can simultaneously challenge social norms and tacitly enforce them; (4) competing models of psychiatric theory from different philosophical perspectives; and (5) the concept of 'mental disorder'. I will review two motifs that cross-cut the five sections.

One motif is that psychopathology is a heterogeneous group of conditions, and as such, is difficult to characterize concisely. The first section of the book explores various symptoms as derangements in how some individuals experience themselves and the larger world. Grant Gillett explores psychosis through the lens of cognition, showing that some psychotic experiences may better characterized as cognitive mishandlings of shared experiences, rather than as false idiosyncratic experiences. George Graham similarly characterizes thought insertion as a dysregulation of subpersonal information and a failure of self-ascription. Alan Soble looks at the inconsistent presence of distress in paraphilias, suggesting that we need a more nuanced way to describe certain drives, impulses and desires than to call them all 'disorders'. Alfred Mele argues a similar point: his sensitive depiction of addictive illness as a failure of volition and an inability to adhere to one's "personal rules" suggests that some addictions may be more compulsive than others, and that people succumb differently to proximal rewards. Louis Charland questions how we can best understand personality, from medical, social, and philosophical points of view. He argues that what the DSM calls 'personality disorders' are a disparate group of derangements, in which some are better conceived as moral or social anomalies rather than illnesses in the traditional medical sense. All of these discussions call attention to limitations of traditional characterizations of psychiatric illness.

A second motif is the inescapable influence of values in psychiatry. This motif pervades all five sections. For example, in his discussion of personality disorders, Charland argues that as moral rather than medical problems, Cluster B disorders may best be treated outside of a medical purview. Part of Jennifer Hansen's sensitive discussion of depression considers moral and medical explanations of depression as alternatives with greater or lesser socio-political valences. The 'Antinomies of Practice' in Section 2 continue the motif. John Sadler's analysis of diagnosis explores the role of values that contribute to stigma, attributions of or excuses from responsibility, and our associations of certain disorders with particular social goods, such as creativity. Bill Fulford's solution to the (usually) tacit fact/value tension in medicine is to promulgate a system of "Values-Based Medicine" to parallel the current emphasis on evidence-based medicine.

The values that influence psychiatry most pervasively, and for which psychiatry is often criticized, are brought to the fore in Section 3: "Norms, Values, and Ethics". Many of these chapters explore some of the more familiar ethical concerns regarding psychiatric practice and theory, such as discussions of responsibility, autonomy, and personal values that mutually shape psychiatry and as they also are shaped by it. This section also includes especially nuanced discussions of race (Marilyn Nissim-Sabat) and gender (Nancy Potter) that remind us that power differentials and social biases pervade all of medicine, not just psychiatry. Potter's sensitive discus-

sion of gender explores how social inequities and values can be expressed even in the basic, objective, medical conception of gender. Medical concepts beyond mental disorders are subject to distortions and manipulations, and they inculcate social imbalances for both men and women. She argues that social expectations for both genders can be codified into medical concepts generally, creating 'pathology' for anyone who falls outside social expectations.

The greatest weakness of this book is that its balance of philosophy and psychiatry is uneven. There is no question that this is a philosophy book: readers from other disciplines may find some of the essays technically challenging. Some of the essays are instructional, and constitute excellent introductions to the topics at hand; others assume a considerable familiarity with philosophy, especially in the last two sections. Conversely, some authors are better versed in psychiatric theory than others; others give too much credence to the profession's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) as a conveyor of psychiatric epistemology, ontology, and theory. However, this unevenness is to be expected given the range of experience represented here. To their credit, all of the authors clearly take psychiatry seriously, and provide careful, thoughtful analyses that address psychiatry's conceptual challenges head on. There are no straw men here.

Review

Healing Psychiatry: Bridging the Science/Humanism Divide,
David Brendel. Cambridge, MA:
MIT Press, 2006.

Christian Perring, PhD

David Brendel starts off *Healing Psychiatry* with the premise that psychiatry is divided; he cites Luhrman's *Of Two Minds* as evidence. The split is mainly between psychodynamic and biomedical models, and lies not just in the sociology of mental health professionals, but also in the theoretical models available to them. Brendel aims to bring the two theoretical stances together through a pragmatic approach. He argues that this approach can combine humanism with science in a coherent fashion. He sets out his program in chapters addressing clinical cases, the mind/body problem, psychoanalysis, neurology, psychiatric diagnosis, and the future of psychiatry. This leaves no doubt that Brendel has an ambitious program.

Brendel conceives of himself as drawing on the work of Pierce, James and Dewey in his pragmatist approach. He highlights four principles which he calls the four *p*'s: "(1) the *practical* dimensions of all scientific inquiry; (2) the *pluralistic* nature of the phenomena studied by science and the tools that are used to study those phenomena; (3) the *participatory* role of many individuals with different perspectives in the necessarily interpersonal process of scientific inquiry; and (4) the *provisional* and flexible character of scientific explanation." (p. 29). Brendel does a good job at showing that the American pragmatists did indeed hold these principles. However, it is less clear that these are distinctively pragmatist principles that would be rejected by other perspectives. There is little to be gained by asking if his program is truly pragmatist, especially since philosophical pragmatism is such an amorphous collection of doctrines. It is worth noting, though, that as they stand, the 4 *p*'s could be accepted by mind/body dualists, biological reductionists, phenomenologists, scientific antirealists, Davidsonians, Freudians, and advocates of eclectic psychiatry. Indeed, Brendel is careful to distance himself from a pragmatist theory of truth and makes clear he is committed to scientific realism and the empirical testing of beliefs, which he identifies as the tradition of Peirce, James and Dewey (p. 34).

Regarding pluralism, Brendel emphasizes that it is important for physicians to take into account not only biomedical considerations in their clinical practice, but to also to bring in diverse human values. He explains that, "There is no single set of clinical considerations or ethical theories to guide the physician and the patient to the most appropriate

14th International Conference on Philosophy, Psychiatry and Psychology

Ethics, Experience and Evidence: Integration of Perspectives in Psychiatry

September 2-4, 2011
Gothenburg, Sweden

Psychiatry seems to be in a permanent state of tension. First, there is the methodological tension. The natural-scientific view that underlies most of medical science competes with a number of broadly phenomenological perspectives. Another important source of tension is the dialectic between empirical facts and values (moral and others) accepted by the psychiatrist and/or the society.

The aims of this conference are: to scrutinize some fundamental tenets of natural-scientific and phenomenological psychiatry; to investigate if, how, and to what extent these seemingly opposed viewpoints can coexist peacefully; to discuss in which ways ethical and other values can be integrated with the different methodological perspectives.

More concretely, the meeting focuses on: evidence-based practice in psychiatry; the nature of phenomenology and phenomenological psychiatry; the interaction between facts and values in diagnostic considerations.

The conference is organized by the Swedish Association for Philosophy and Psychiatry, in cooperation with the University of Gothenburg, the Swedish Psychiatric Association, and the International Network for Philosophy and Psychiatry. For more information, consult the Web Site.

Web Site
http://sffp.se/eee/

decision-making process in the context of clinical complexity, ambiguity, and uncertainty." (*Ibid.*) He does not spell out how we can combine individual single sets of clinical considerations or ethical theories to come to a final decision, but obviously, his point is that one must take into account a wide variety of points of view. This raises the question of how one should weigh these clinical data and theories: should Chinese medicine be given as much weight as Western medicine, for example, or should eugenic ideology be given as much weight as the belief in the equal worth of all humans? Brendel later makes it clearer that his point regarding clinical treatment is that physicians should not be so devoted to one theoretical viewpoint that they ignore good data that show that forms of treatment allied with different viewpoints are successful. Thus, one can conclude that Brendel would argue that physicians should be ready to include Chinese medicine as part of treatment if it is empirically supported. Yet it is hard to imagine who would disagree with this; the argument comes when the debate moves to what counts as good empirical support.

In relation to the participation of many individuals with different perspectives in scientific inquiry, Brendel mentions the importance of involving the patient in clinical care. This seems to mix up two things: the physician/patient interaction, in which in standard cases, it is the patient who makes the decisions with the help of the physician, and physicians' search for medical knowledge, where the physician is the primary agent, but may be helped by understanding the perspective of the patient. While good care requires good knowledge acquisition, the projects of gaining knowledge and caring for the patient are not necessarily linked.

Finally, the idea that science is open-ended and its conclusions subject to revision is one with which all will agree; Brendel emphasizes medical uncertainty, which is certainly wise, but nobody could claim that medicine has all the answers yet. He makes clear that his targets here are reductionists and ideologues who are dismissive of other views. It is not hard to believe that such people exist, but it is clear to all theorists of medicine, whatever their perspective, that such dogmatic views have no place in clinical practice.

This leaves readers in considerable doubt that Brendel has succeeded in setting out a pragmatist theory that is distinguishable from competing philosophical theories. Rather, we might see the principles in the four *p*'s as guiding qualities for good clinicians with which everyone would agree. This indeed might be in Brendel's favor: rather than tying his approach to a controversial and possibly faddish theory in philosophy, he can claim that he is able to solve the conceptual divide in psychiatry simply by appealing to principles with which everyone will agree. It could equally well be named "sensible evidence-based psychiatric realism." Indeed, when Brendel discusses six cases of patients he has treated, he makes a strong case that the four principles are useful. They cannot be applied in a syllogistic way to force particular conclusions, but they do function as guidelines for good practice. Obviously the principles by themselves are not sufficient for good practice, and one might wonder how much work they are really doing in each case. Nevertheless, there is no doubt that they would be good guidelines to use in clinical training.

Yet the question remains what is distinctive about Brendel's approach over and above being clinical common sense? Consider his discussion of biopsychiatry. In his chapter on the mind/body problem, he reviews the literature and argues for a non-dualistic non-reductive pluralism, that aims to explain psychological phenomena using a range of concepts at all levels of descriptions, from the neurochemical all the way to the social. Thus, Brendel, along with nearly all other current philosophers of mind apart from the Churchlands, rejects eliminative materialism. He builds on this in his chapter on neurology and psychiatry, where he argues that a purely neurological approach to mental illness is insufficient, especially in regards to clinical treatment, where it is important to pay attention to issues of meaning and interpersonal factors. This is certainly very plausible, but who would disagree? We might possibly treat stroke as a purely neurological dysfunction, but we certainly would not treat panic disorder in this way. Of course, there are some theorists who believe that some symptoms are best understood as neurological and thus without meaning: one could take the delusions of people with schizophrenia as basically effects of brain dysfunction, or one could take them to be expressions of deeper emotions that need to be investigated in psychotherapy. It's an empirical question as to which view is right. Those favoring neurological approaches hope that the time will come when we have a neurological account of deeper emotions, and Brendel quotes from a paper by some who claim that the boundaries between neurology and psychiatry are growing less distinct. Doubtless there are some who make overblown claims for a neuroscientific understanding of the mind. However, Brendel seems to take such claims as his main opponent, thus leaving himself with an easy win. It is conceivable that at some point in the distant future, a fully-developed neuroscience may genuinely have a chance of replacing other sciences of mind and at least shifting hermeneutic approaches to the sidelines. However, we are not at such a stage yet, and it is unlikely that we will ever get there. So Brendel's arguments against a purely neurological approach at this stage are strong, but almost entirely uncontroversial, and he does not grapple with any arguments for the view he is opposing.

The discussion on psychiatric diagnosis is where Brendel is most successful at showing how his four principles make a difference. This is largely due to the fact that the major disagreements regarding classification are not basically empirical, while the treatment issues that Brendel considers in other chapters are. With classification, the question is what sort of scheme to use, and what its relation to scientific knowledge and clinical practice should be. Brendel surveys some of the history of classification, and points out that DSM-III and its successors are not genuinely atheoretical, since for several diagnoses, the causes are specified.

For example, there is a category of "major depressive disorder due to a general medical condition." Brendel argues that the diagnostic system would be made more flexible and pluralistic if there were more categories of mental disorder including psychosocial causes, and he argues this would be useful for physicians and researchers, since it would help with treatment planning and would enhance the conceptual integration of psychiatry. He uses a few examples to illustrate his point, and makes it clear that a biomedical approach to classification that plays down the importance of psychosocial causes is not in the best interests of clinical psychiatry or patients. However, Brendel says nothing about the distinction between normal and abnormal conditions, and this is disappointing. It would be interesting to see how application of his 4 *p*'s could help with this issue, which is closely related to psychiatric classification. What he does say is intriguing but it does not go very far. His approach to classification is certainly plausible as far as it goes, but the real test comes when we see how it plays out when brought to some of the more contentious cases in classification, such as categories of Cluster-B personality disorders, dysthymia, or pre-menstrual dysphoric disorder.

Brendel finishes his book looking at the future of psychiatry and explaining how his pluralistic approach can heal the rift in the field, bringing together humanistic and biomedical approaches. He warns against a overconfidence in psychiatric science, but he also insists on the dangers of neglecting science. So he aims for a moderate approach that is able to steer between the scientism and non-scientific humanism. Indeed, what is distinctive about Brendel's approach is its moderation. He embraces all views that are reasonable and advocates their peaceful coexistence, with the ultimate goal of helping patients. It is in his final chapter that he really emphasizes moderation as a pragmatist goal, quoting Louis Menand (2001) in support of this interpretation.

Healing Psychiatry makes a strong case that it is better to aim for conceptual and theoretical pluralism rather than unity, and once we accept this, then the different perspectives of psychiatric theoreticians of different stripes do not seem so problematic. The rift between biomedical and psychosocial views can be healed not by insisting on one right answer, but rather by getting each side to acknowledge the validity in other perspectives. As a position document establishing the feasibility of a middle ground, and showing the problems inherent in extremism, Brendel's book is successful. It would have been helpful if he had engaged more with authors who are firmly in favor of one side of the psychiatric divide, and have no interest in seeing the value in the other side. However, few philosophers of psychiatry adopt such extreme views. This leaves one wondering how useful the 4 principles are in addressing some of the major debates in psychiatric philosophy and ethics, such as whether psychotropic medications are overprescribed, when people with mental illnesses should have the right to refuse treatment, or whether substance dependence is a legitimate disorder. The 4 *p*'s take us some way towards addressing such questions, but it is relatively clear that they will not dictate any particular answers. Brendel never claims that they would, of course, but we are left wondering how much they can guide us, once we

The Truth About Trauma Essay/Review

Trauma, Truth and Reconciliation: Healing Damaged Relationships,
Nancy Potter. (ed)
Oxford, Oxford University Press, 2006.

J. Melvin Woody, PhD

Remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of wounds.
Judith Herman, *Trauma and Recovery*[1]

The truth about people is hard to know.

There is much that they will not say, and much of what they say is only partly true. There is also much that people simply cannot say because they themselves do not know, because many realities defy introspection.
Kuriyama, *The Expressiveness of the Body*[2]

What is the truth about trauma? Must one discover the truth in order to recover from trauma? The relationship between truth and trauma poses a conundrum that has perplexed psychiatry since its advent in the works of Charcot and Janet, Freud and Breuer. Psychiatry virtually began with the hypothesis that pathological hysteria could be cured by remembering and telling the truth about terrible events. More recently, shattered societies have sought healing reconciliation through remembering and telling the truth about political atrocities like “ethnic cleansing” or South African apartheid.

In 2004 the AAPP annual meeting focused on ”the intersection between mental health and mechanisms for reconciliation from conflict and past wrongs.” The sessions explored the parallels and differences between psychiatric and social responses to traumatic atrocities, with particular attention to the comparison between various forms and theories of therapy and the sort of truth and reconciliation commissions established in South Africa and elsewhere that tried to heal whole societies in the wake of social atrocities. Nancy Potter has wrought the essays resulting from that meeting into a remarkable book. *Trauma, Truth and Reconciliation* is not a typical anthology of conference papers. Potter has persuaded the conference presenters to think of their contributions as chapters in a developing inquiry rather than as disparate essays. As a result, the book reads rather like a serial novel, in which each author takes up the tale where the previous chapter left off, although the successive chapters forward an inquiry rather than narrate a story. The inquiry advances through a dialectical interplay of diverse perspectives that challenge and complement

one another. The resultant whole provides an especially effective illustration of the fertility of the dialogue between philosophy and psychiatry. Potter's *Introduction* provides an efficient survey of the several chapters, which frees me to dwell on the central critical issues about truth and reconciliation.

Freud originally thought that he had discovered the source of hysteria by tracing the roots of present pathology to their origins in traumatic historical events that had been repressed from conscious memory. He hoped to cure his patients by eliciting conscious memory of those events through analysis. But his hopes for cures were disappointed and he soon concluded that the elicited "memories" were not true but only recollections of childhood "fantasies." Freud is now severely criticized for abandoning his original seduction hypothesis – and Judith Hermann points out that Freud's change of mind reflected a more general, social amnesia or refusal to confront the truth about unspeakable atrocities, both personal and social.[3]

Yet in one way, Freud's retreat made sense. The objective historical truth is not easily ascertained – among other things, because the testimonies of participants and witnesses to an event are always partial and biased. The historian must always carefully balance testimonies against one another and against other evidence, whereas the clinician must concern himself not with an event *an-sich,* which no one experienced *as* such, but with how the patient-victim experienced the traumatic event, an experience that could scarcely be unbiased or objective. In any case, it seems reasonable to conclude that what counts for purposes of psychotherapy is not what actually happened, but what the patient *thinks* occurred.

Freud soon stepped back from attempting to function as a historian. Indeed, he was in no position to conduct the sort of inquest undertaken by the South African Truth and Reconciliation Commission. (He could scarcely question the fathers he originally suspected of engaging in incestuous acts that traumatized their daughters.) But he didn't merely retreat to his patients' experience of actual events. Instead, he retreated from the interpersonal to the intrapsychic and concluded that the traumas he had descried as the source of hysterical symptoms were only "fantasies," wishful thinking. The task of therapy, then, was reconceived as uncovering the truth about the patients' childhood fantasies.

But whether real or imaginary, we must still ask, how might the truth about those childhood events be ascertained? Does the patient-victim really know the truth about the child's trauma experience? Freud's patients denied any recollection of them. He reasoned that they had not simply been forgotten, but were actively being repressed and were accessible only through the archeological hermeneutics of psychoanalysis, which would exhume them from the unconscious and bring them to light through language, the organ of consciousness. The success of the therapy would establish the pragmatic truth of the analyst's interpretation.

I have lingered on the early Freud because this "cathartic" model of therapy has persisted in the popular conception of psychoanalysis and in many contemporary forms of therapy – and because this model especially invites comparison with truth and reconciliation strategies for dealing with both personal and social traumas produced by ethnic cleansing, terrorism and the political use of such violent means as torture and rape.

The trouble is that the cathartic model didn't succeed. It only offered symptomatic relief and Freud soon abandonned it himself. Scarcely two years after the publication of *Studies on Hysteria* Freud wrote to Fliess that the analyses described therein had not been complete and had not resulted in cures, only in remission of symptoms.[4] Will discovering the truth about trauma prove any more possible or therapeutic today? There is no simple answer because in cases of trauma, epistemology and pathology converge and confound one another. Even when the traumatic event is only a day or two old and presumably "freshly in mind," it is far from clear that telling about it will prove therapeutic. Trauma sufferers often have great difficulty recalling or describing what happened to them. And yet, contrary to Freud's hypothesis, memories of trauma typically prove *irrepressible*. The traumatic events are not merely recollected, but *relived*. The experiences seem to recur so vividly that they are unlike all ordinary memories. The victim experiences the sounds, colors, affects, even the odors of the original events again and again. But these flashback replays of the trauma don't really help to ascertain the truth about what happened. Bessel van der Kolk sums up this problem nicely in an essay on "Trauma and Memory:"

> The irony is that although the sensory perceptions reported in PTSD may well reflect the actual imprints of sensations that were recorded at the time of the trauma, all narratives that weave sensory imprints into socially communicable stories are subject to condensation, embellishment, and contamination. Although trauma may leave an indelible imprint, once people start talking about these sensations and try to make meaning of them, they are transcribed into ordinary memories—and like all ordinary memories, they are then prone to distortion. People seem to be unable to accept experiences that have no meaning; they will try to make sense of what they are feeling. Once people become conscious of intrusive elements of the trauma, they are likely to fill in the blanks and complete the picture
>
> Like all stories that people construct, our autobiographies contain elements of truth, of things that we wish had happened, but did not, and elements that are meant to please the audience. The stories that people tell about their traumas are as subject to distortion as people's stories about anything else.[5]

Even if the truth about either the objective event or the subjective experience *could* be established, whether by a truth and reconciliation commission or court of law or therapist, Freud's disappointment with the method of catharsis and abreaction

reminds us that there is reason to question the therapeutic efficacy of proclaiming that truth. In recent years, that strategy has been modified for preventive use by "debriefing" victims and witnesses in the immediate aftermath of disasters, while the memory of the event is still fresh. But narration doesn't seem to work any better as an antidote than as a cure for PTSD. Evaluative studies have raised serious objections to the notion that truth will triumph over trauma and even suggest that asking the victim to describe the experience may do more harm than good.[6] Bessel Van der Kolk explains why such narrative therapies tend to aggravate and perpetuate rather than cure post- traumatic stress disorder:

> Describing traumatic experiences in conventional verbal therapy is likely to activate implicit memories, that is, trauma-related physical sensations and physiological hyper- or hypo-arousal which evoke emotions, such as helplessness fear, shame and rage. When this occurs trauma victims are prone to feeling that it is not safe to deal with the trauma and, instead, are likely to seek a supportive relationship in which the therapist becomes a refuge from a life self-experience of anxiety and ineffectiveness.[7]

In any case, individual health is not the only problem raised by traumatic events. Restoration of the mental health of the victim of rape leaves the rapist at large. By abandoning the seduction hypothesis, Freud evaded the underlying problem of child abuse. Effective therapy for victims of war or terrorism or social injustice does not cure the communal ills that produced or were produced by the traumatic event. Such events raise issues about justice and social harmony as well as individual health. We face such issues today as we consider whether to fully disclose the truth about American treatment of prisoners at Guantanamo and Abu Ghraib. Would thorough investigations or trials of those responsible for the renditions and "enhanced" methods of interrogation serve justice, whatever the cost in political, social and international discord? *Fiat justitia, pereat mundi*!? Or should we forgive and forget, look forward instead of backward, in order to live and act harmoniously? In Rwanda and Kenya, Argentina and Chile, these questions loom even larger – as they do for abused wives or children.

I have here attempted to highlight the difficult questions raised by the relations between trauma, truth and reconciliation. The essay-chapters that Nancy Potter has assembled in *Trauma, Truth and Reconciliation* probe those questions from diverse vantage points and with great subtlety. Together, they offer a remarkable inquiry into the interplay between the conditions of individual and community well-being.

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Review

The Concepts of Psychiatry: A Pluralistic Approach to the Mind and Mental Illness,
S. Nassir Ghaemi, M. D.
Baltimore, The Johns Hopkins University Press, 2003

Donald Mender, M. D.

Nassir Ghaemi's thoroughgoing and insightful volume, *The Concepts of Psychiatry*, raises critical questions about the philosophical foundations of contemporary psychiatry and goes a long way toward addressing them. The book aims its pragmatic critique at the dual theoretical extremes of monistic dogmatism and over-inclusive eclecticism undergirding today's psychiatric thinking.

Dr. Ghaemi identifies as problematically monistic dogmas both psychopharmacological materialism and psychotherapeutic idealism. He indicts biologically reductionistic dogmatists for dismissing out of hand the explanatory value of meaning and the therapeutic potential of dynamic interpretation. He condemns idealistic psychoanalysts as well for ignoring a priori the relevance of neural plasticity to those psychological benefits wrought by subjective introspection.

He connects over-inclusive eclecticism with the biopsychosocial model advanced by Adolf Meyer and George Engel and with the philosophical "agnosticism" claimed by proponents of DSM III and IV. Dr. Ghaemi roundly criticizes such eclecticism as vacuously unfocused. In his view, eclecticism inappropriately attempts to

apply in an indiscriminately even-handed manner both biological and psychosocial paradigms across the board to all psychiatric issues, no matter how irrelevant one particular philosophical viewpoint might be to a specific clinical problem.

In place of either dogmatism or eclecticism, *The Concepts of Psychiatry* instead advocates a middle road, which Dr. Ghaemi calls a philosophically "pluralistic" stance. He derives his notion of pluralism from the writings of Karl Jaspers, Leston Havens, Paul McHugh, and Philip Slavney.

These thinkers differ slightly from each other in terms of the philosophical categories into which they divide psychiatric paradigms; for instance, Havens distinguishes objectve-descriptive, psychoanalytic, existential, and interpersonal schools of psychiatry, while McHugh and Slavney differentiate psychiatric orientations according to emphasis on a patient's disease, personal traits, behavior, and life goals. In contast, all the pluralistic authors cited by Dr. Ghaemi hold in common with each other and with eclecticists the idea that the fullest range of conceptual reference frames should be considered with regard to the general aggregate of issues encountered by psychiatrists.

Most crucially, however, those same pluralists decisively part company with eclecticism by requiring that for every practical clinical problem a different spectrum of weights be assigned to the relevance of each philosophical perspective. Hence, for example, vulnerability to borderline personality disorder may entail a minor degree of genetic loading and some element of early neurobiological imprinting, but in practical terms the syndrome remains at present best understood and treated through predominantly psychological means; the management of bipolar illness may draw supplementary sustenance from long term psychoeducational work to help patients recognize triggers, but acute mania demands a largely biological intervention to achieve initial stabilization; optimal therapeutic approaches to chronic paranoid schizophrenia call for equally apportioned aliquots of psychosocial support and medication.

The Concepts of Psychiatry justifies its pluralistic imperative by adopting an inductive-pragmatic view of science, a quasi-Darwinian take on diagnosis, and a virtue-ethical notion of therapeutics. These scientific, diagnostic, and therapeutic perspectives parallel the book's pluralism insofar as all such approaches chart spectrally calibrated middle paths between philosophical extremes.

Dr. Ghaemi's view of science, modeled on the ideas of Francis Bacon and Charles Sanders Peirce, steers a measured, inductivist course between Karl Popper's strict deductive requirement of empirical falsifiability and the total relativism of conventionalists such as Thomas Kuhn and Paul Feyerabend. This brand of inductivism embraces a reasoning more flexible than the Popperian modus tollens but tighter than the bifurcation of rationalities embodied by Hume's fork. In particular, Dr. Ghaemi endorses Peirce's notion of logical convergence, adapted for psychiatry's use by Jaspers, to show that pluralism can provide progressively closer theoretical approximations of reality through the use of inductively accumulated empirical data that will inform and shape the relative spectral weighting of different conceptual frameworks in their application to specific clinical problems.

Dr. Ghaemi's perspective on diagnosis, drawn from Darwinian concepts of evolving biological populations and the ideal types of Max Weber, plots a customized route between the essentialistically absolute reifications of natural kinds, "carved" into nature at its putative "joints," and relativistic assaults on taxonomy, leveled against psychiatric nosologies like DSM by "antipsychiatrists" such as Thomas Szasz and Michel Foucault. In particular, Dr. Ghaemi supports Jaspers' use of ideal types in the understanding of individual psychiatric diagnoses as selected reference points around which species-normed clusters of varying clinical data may be organized for purposes of intersubjectively comprehensible discussion.

Dr. Ghaemi's virtue-ethical notion of therapeutics, inspired by the writings of Aristotle and Alasdair MacIntyre, traverses a middle road between the consequence-oriented hedonism of utilitarians like John Stuart Mill and Jeremy Bentham and the austerely duty-bound deontology of Immanuel Kant. In particular, Dr. Ghaemi adapts to psychiatry the Aristotelian equation of virtue with lifelong characterological cultivation of moral habits learned in Humean fashion, neither bending inordinately to the pleasure principle nor hewing rigidly to static, congealed commandment.

The great strength of *The Concepts of Psychiatry* is its consistency of commitment to commonsensical, practical moderation: pluralistic but measured flexibility in matters of metaphysics, inductively pragmatic convergence toward an asymptotic goal of empirical accuracy in the development of serviceable scientific hypotheses, normative evolution of statistically clustered diagnostic guidelines in the temperate pursuit of reliably communicable nosology, and practiced refinement of ethical virtues in the honing of therapeutic habits. All these prescriptions for 21st century psychiatry reveal Dr. Ghaemi to be a steadfast guardian of mental health care in the most immediately human way possible, as an ontological narrator of epistemologically open-ended but morally sensitive praxis.

Yet does Dr. Ghaemi's pragmatic pluralism push today's scientific psychiatry as far as it can go toward a positive tomorrow? A hint that the answer to this question is "no" lies in his book's exploration of science a la Dilthey and Jaspers as an effort toward both causal explanation and semantic understanding. As *The Concepts of Psychiatry* points out, explanatory objectivity has generally appeared to trump intentional subjectivity across the sweep of science's history, but Dr. Ghaemi's book never quite fleshes out the finer historical structure of progressively convergent interdigitations between causation and referential meaning.

The past unfolding of scientific progress shows that specific theoretical revolutions have most effectively, ele-

gantly, and directly transcended the entrenched resistance of "normal" paradigms by subjectively decentering old frames of scientific reference and thus reducing the divergence of theories from objective facts. For example, Copernicus eliminated the burdensome use of overly complicated epicycles in celestial mechanics by moving the observing scientific subject away from the center of planetary orbits, while Darwin naturalized the byzantine artifice of Linneus's taxonomic hierarchy by displacing homo sapiens from its apex.

It is yet possible that the pragmatically pluralistic lens through which Dr. Ghaemi now urges us to view the measured progress of our present "normal" psychiatric sciences, with all the currently existing limitations upon their spectral convergence, will in the future yield to revolutionary theoretical unification, monistic yet free of dogmatic oversimplfication, if some subjectively pseudo-centered assumption, now occultly constraining all our present psychiatric theories, can be exposed and debunked. Such a change might transform away in a still unforeseen manner our contemporary illusion of complexity through a new locus for the subjective reference frame of psychiatry.

Today's psychiatric professionals, whether monistic, eclectic, or pluralistic, may be too close to relevant phenomena to bring the coming unified paradigm into convergent clarity. Instead, a key conceptual breakthrough may have to originate within some other field of study and only later diffuse into the universe of psychiatric thought.

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Review

Essential Philosophy of Psychiatry,
Tim Thornton,. Oxford,
Oxford University Press, 2007

James Phillips, M.D.

With *Essential Philosophy of Psychiatry* Tim Thornton has provided us with a rich and interesting survey of issues in the philosophy of psychiatry. In reviewing this volume we can't fail to notice a couple of Thornton's introductory remarks that guide us in approaching the book. He tells us that, in contrast with the older tradition stemming from Karl Jaspers' work in the early 20th century, the "new philosophy of psychiatry is a developing field within Anglo-American, broadly analytic philosophy" (p. 2). This may surprise some readers, unaware that the recent resurgence of work in this interdisciplinary area is an exclusive province of analytic philosophy. The volume does indeed confine itself for the most part to work in the analytic tradition, and certainly a quick look at the contents of *Philosophy, Psychiatry, Psychology*, as well as the bulk of books published in the Oxford IPPP series, lend support to Thornton's thesis. But however overstated his claim may be, Thornton does invite us to include, with an assessment of his survey, the question: how well has analytic philosophy done in the philosophy of psychiatry?

Another remark in the Introduction leads us in another direction of assessment. Thornton writes: "...unlike some areas of philosophy, philosophy of psychiatry can have a real impact on practice. It is a philosophy of and for mental health care. It provides tools for critical understanding of contemporary practices, of the assumptions on which mental health care more broadly, and psychiatry more narrowly based, are based. It is an area where philosophical work is carried out by practitioners and services users, as well as professional philosophers" (p. 1). So here we have another question, that of utility for practice of the new philosophy of psychiatry.

Thornton organizes the book into three parts: Values, Meanings, and Facts; and each part into two chapters. He devotes the first chapter of Part I, "Anti-psychiatry, Values and the Philosophy of Psychiatry," to the challenge raised by Thomas Szasz' critique of psychiatry in the early 1960s (Szasz 1961). Indeed, Thornton describes the rise of the new philosophy of psychiatry as a response to the challenge raised by Szasz and the anti-psychiatry movement of the 1960s. To the American reader, it seems like an odd starting point since Szasz' critique was dismissed so long ago and is mostly ignored in the US.

There is certainly a logic in this starting point in that the main theme of Szasz' myth of mental illness was that a rigid line divided medical illnesses, which are physiologically based and value-free, from so-called mental illnesses, which in contrast have no basis in pathophysiology and are heavily value-laden. Further, for Szasz, to the extent that any mental illness could be associated with brain abnormality, it should be relabeled a brain disease and be incorporated into neurology. Thornton reviews the history of this debate, beginning with the work of Kendell and Boorse, each arguing that the major psychiatric illnesses could be described in value-neutral terms as forms of biological dysfunction and thus warrant the same designation of illnesses as other medical illnesses. He then proceeds to the work of Bill Fulford (1989), who in an ingenious (and mischievous) gesture, turned the debate entirely on its head by reframing the discussion to the effect that, rather than arguing for a value-free psychiatry, the issue is to recognize that *all* illness - psychiatric *and* medical - is value-laden. In his analysis Fulford explains that although values intrude on all illness, mental illness is more overtly value-laden because psychiatric conditions involve more complex areas of human experience such as emotion, volition, and belief.

Thornton concludes the first chapter with an extended discussion of Jerome Wakefield's "harmful dysfunction" analysis of mental illness, a effort to separate out an evaluative component ("harmful") from a purely non-evaluative, descriptive component (evolutionarily based "biological dysfunction") in the definition of mental illness.

In the second values chapter, "Values, Psychiatric Ethics and Clinical Judgement," Thornton shifts his focus to the larger issue of conducting mental health care in an ethical manner. After reviewing the major contemporary philosophical approaches to ethics, he settles in on the "Four Principles" approach championed by Beauchamp

and Childress. In their *Principles of Biomedical Ethics* (Beauchamp and Childress 2001) they enunciate four principles - autonomy, beneficence, non-maleficence, and justice - that, they argue, can sufficiently organize an ethical approach to medical care. In brief, these principles can be summarized as: give priority to the patient's autonomy, work for the patient's benefit, avoid harm, and distribute care in a fair manner. Thornton then describes how these general principles of medical ethics are rendered more complicated by the specifics of mental health care. The most obvious example is compulsory care (involuntary commitment) in psychiatry, in which there is a question of conflict between the principles of autonomy and beneficence.

Aside from this core problem in clinical practice, further complications in mental health ethics - and thus further conflicts among the four principles - stem from the multiplicity of values in psychiatric care. To shed some clarity on this increasingly complicated area, the author invokes Fulford's "Ten Principles of Values-based Practice" (Fulford, 2004). Thornton's interest here is in elucidating the philosophical underpinnings of the ten principles, which he summarizes as the irreducibility of values to facts, the subjectivity of values, and the uncodifiability of values. These philosophical implications make values-based practice a radical approach to mental health ethics - in contrast, for instance, to more conventional approaches such as the four-principles approach of Beauchamp and Childress, which depend on notions of value-free diagnosis and simple application of principles to allow for an unambiguous, unmessy ethical practice.

This dilemma leads Thornton to the final and most interesting section of the chapter, an argument for what is called 'particularism' to deal with the core problem of the four principles in mental health care. The issue is that although Beauchamp and Childress claim for their principles only the status of guidelines, they evince a fear that, unless there is some way to use and balance the principles in an algorithmic manner, we will be left with principleless, arbitrary judgments regarding care. Thornton aims to broaden the choice between algorithmic rigidity and clinical chaos with the use of particularism. "...the idea is that, rather than thinking that a particular situation merely prompts a balancing of conflicting principles which themselves discipline a judgement, one should think that the aim of the judgement is just to get the situation right. On this third view, the situation itself contains evaluative features - values - and ethical judgement aims to describe these. This view is called 'particularism' " (78). I am in thorough agreement with this approach and will add a footnote to the discussion. The bottom-up approach advocated by the author - begin with the concrete situation and allow it to guide, as well as be guided by, the general principles - was described in an eloquent and unsurpassed manner 2500 years ago by Aristotle in the *Nicomachean Ethics*, described by Alasdair MacIntyre as "the most brilliant set of lecture notes ever written" (MacIntyre 1981, 147). For Aristotle, unlike scientific or theoretical knowledge, the essence of *phronēsis* (practical wisdom) is the ability of the experienced wise man (the *phronimos*) to apply general principles to the particular situation and make a wise judgment that addresses the uniqueness of the particular case.

Regarding particularism, then, I have two thoughts. First and most obvious, is this an instance in which the 'new' analytic philosophy of psychiatry has, as it were, rediscovered the (Aristotelian) wheel? Second, I am left to wonder whether, in his emphasis on the values inherent in the situation as opposed to the judgment of the experienced clinician, the author, a little uncomfortable with his own defense of particularism, hopes that those values inherent in the situation will comfortably direct the clinician in his judgment and relieve him (and us) of the burden of that ineluctably contingent judgment.

Part II of the book is entitled Meanings, and the first of the two chapters is entitled "Understanding Psychopathology." The chapter first takes up Jaspers' seminal contribution in his *General Psychopathology* (Jaspers 1963 [1946]) and related papers, and then takes up the specific issue of understanding delusions and delusional experience. The section on Jaspers is disappointing in that it does little more than offer an exposition of Jaspers' rather confusing concepts without an examination that would make them more useful to the general reader. As is well known, Jaspers challenged the overly positivist vision of nineteenth-century psychiatry with his presentation of psychiatry as a mixed discipline involving both explanation and understanding - this distinction reflecting Wilhelm Dilthey's earlier distinction between explanation (*Erklären*) as the method of the positive sciences (*Naturwissenschaften*) and understanding (*Verstehen*) as the method of the human sciences (*Geisteswissenschaften*). As useful and important as that general distinction was for psychiatry, what Jaspers then did with it was and has remained puzzling.

First, as Thornton describes, Jaspers added, on the side of understanding, a distinction between phenomenology and genetic understanding, and into that mix he added a further distinction between objective and subjective symptoms, with empathy being a specific inroad into the latter. Thus, mental experience of the patient that can be grasped "rationally" falls into the category of objective symptoms and is not subject matter for understanding in either of its forms. For Jaspers, phenomenology is a form of static understanding, while genetic understanding is the effort to understand the connections between one psychic experience and another. Phenomenology attempts to describe the pure subjective experience of the patient, while genetic understanding tries to understand the connections between such experiences.

What is wrong with this picture? First, there is no obvious reason to erect this barrier between what Jaspers calls phenomenology and genetic understanding, and in the case of subjective experiences seen in the consulting room, it is probably not even possible. Presumably Jaspers got the notion of phenomenology from Husserl, for

whom, for instance, it would be a task to give a precise description of a perceptual experience; and the notion of genetic understanding from Dilthey, whose notion of understanding fits Jaspers' category of genetic understanding. But no phenomenological psychiatrist after Jaspers maintained the distinction between phenomenology and genetic understanding.

A second problem involves the issue of empathy, which, according to Jaspers, involves transforming oneself into the psyche of the other. This is a large topic and too much for discussion in this review. The question is what exactly empathy is and whether it is even possible as defined by Jaspers. One thing that is clear is that Jaspers' understanding of empathy is not that of his mentor, Dilthey. For the latter, understanding of the other transpires in terms of the triad: experience, expression, interpretation. In other words, the other has an experience and expresses it in some manner - verbal, non-verbal - and my task in understanding that experience is to interpret the expression. This notion of empathy does not involve Jaspers' metaphor of an inside or an interior that I try to get into.

Finally, Jaspers' analysis of understanding is severely limited by his antipathy to Freud and the latter's concept of the unconscious. It is that self-limitation that renders Jaspers' examples of genetic understanding so trivial - e.g. someone insults me, and I experience hurt feelings. One needn't be a card-carrying psychoanalyst to realize that in clinical experience we routinely confront and interpret psychic connections that the patient is unaware of. To place all such activity off bounds, as Jaspers does, rather dramatically reduces the utility of his analysis of the process of understanding.

The second part of the chapter on "Understanding Psychopathology" takes off from a specific position of Jaspers. The latter was firm in his conviction that what he called primary delusions defied understanding. This conviction has been challenged by several contemporary investigators, and Thornton reviews that recent work in the philosophy of psychiatry. Quite reasonably, Thornton treats these efforts as attempts to make at least some sense of the delusional process, and he argues that to fully "understand" a bizarre delusion would be an oxymoron. He reviews and critiques well known positions: delusions as rational responses to abnormal experiences (Maher 1999), delusions as expressions of philosophical confusion (Sass 1994), delusions as framework propositions (Campbell 2001), the two factor model of delusion (Davies, Coltheart et al. 2002), and delusions seen from an engaged rather estranged perspective (Gipps and Fulford 2004). With regard to the latter, the author recognizes a concordance of the "engaged perspective" with Heidegger's central notion that our primary opening onto the world is practical. Thornton appropriately brings Wittgenstein into this discussion, again recognizing the latter's own focus on what Heidegger calls the world "at-hand" (*vorhanden*) and Merleau-Ponty calls pre-reflective life.

Thornton ends the chapter by invoking the work of the Italian phenomenological psychiatrist Giovanni Stanghellini (Stanghellini 2004), a reminder of the unfortunate fact that recent philosophical discussion of delusion and psychotic experience has failed to integrate analytic efforts with the much earlier work of the continental phenomenological tradition. One simple reason for failure is that essential German work has never been translated into English. Obvious examples are Binswanger's book on delusion and Blankenburg's magnum opus on schizophrenia. Fortunately, Stanghellini has incorporated much of Blankenburg into his work, and Mishara has recently provided an overview of Conrad's work on delusion.

Chapter 4 of the book, the second chapter of Part II, Meanings, is entitled "Theorizing about Meaning for Mental Health Care," begins with a section on cognitivism, the effort to naturalize mind and meaning through modeling mind on an information processing computer. I will not detail Thornton's exposition or critique of the idea of mental states as part of inner space, an assembly of "representations" trapped in the brain or mind and somehow trying to make contact with the outer world, although I am in agreement with the critique. A second section takes meaning in the opposite direction, as generated and existing in discursive exchange with others. Thornton finds the discursive, social constructionist analysis as unsatisfying in its way as was the cognitivist version. In a final section he gives the floor to Wittgenstein, explicating the latter's understanding of meaning as use or practice, and arguing for its merits over the cognitivist or social constructionist accounts.

While very much in accord with Thornton, I am left with several questions - not disagreements but areas where I would like to see him develop his perspective further. The first has to do with what he calls his and Wittgenstein's "relaxed naturalism." He writes: "Meaning can be seen to be a part of the natural history of humans, grounded in our practical abilities. Thus, meaning can be 'naturalized' albeit not in reductionist terms. It is not that reasons are reduced to causes or the space of reasons to the realm of law" (152). This attitude toward non-reductionist naturalism is very appealing, but I don't think that it goes far enough. Specifically, the Wittgensteinian approach to meaning, while leaning toward the practical sphere, remains too cognitive and disembodied. Thornton (as he acknowledges in the conclusion to the book) would do well to find room in his discussion for writers working in the 'naturalizing phenomenology' and 'embodied thought' traditions. In the latter tradition, Mark Johnson (2007) published a book recently that critiques the analytic tradition for its overly cognitive, unembodied notion of meaning. Finally, if Thornton wants to argue for "meaning and intentionality as features of the world which are natural in their own right" (164), he should find a place for Hans Jonas (1966), who argues strongly that meaning and intentionality don't begin with human beings but rather belong to life at every level of the evolutionary scale.

A second issue involves the discur-

sive, practical trend of Wittgenstein's (and Thornton's) notion of meaning. The word subjectivity does not occur in this chapter, and the question is whether the discursive, public, practical approach to meaning allows for the rich, subjective lives we find in our patients (and ourselves). The same question could of course be directed at Wittgenstein's phenomenological counterparts in moving meaning toward the practical and interpersonal sphere, Heidegger and Merleau-Ponty. In this context I will express my personal opinion that discussions of meaning in psychiatry that ignore the rich experience of psychotherapeutic practice will remain regretfully abstract and thin. (I pointed out above that while subjectivity enters the discussion with Jaspers, his aversion to psychodynamic therapy is so strong that, at least in my view, he does not provide a response to the question I am posing here.)

The third and final part of the book is entitled Facts, itself like the first two parts divided into two chapters. The first, Chapter 5, "The Validity of Psychiatric Classification," deals with the factual reality of psychiatric diagnoses. Thornton takes up this theme in the familiar terminology of reliability and validity of diagnosis. He traces the history of psychiatric classification, noting that the effort to make the ICD and DSM more scientific began in 1980 with the use of operationalized definitions in DSM-III, thus assuring reliability, but leaving validity to be dealt with in later versions of the DSM and ICD.

The chapter is thus centered on validity in psychiatric diagnosis. Thornton begins with the question of contamination of validity by the injection of values into the diagnoses, thus invoking again the critique carried out by the anti-psychiatric movement. He agrees with the inevitable presence of values in diagnoses and argues that the critique of classification for that reason is based on a neo-Humean position that values do not exist in nature and are always and only the product of human subjectivity. His response to the critique is to throw into question the neo-Humean position, arguing that "[T]he world contains features whose conceptualisation requires a subject to have particular interests, abilities and even perceptual sensitivities" (p 179).

From there Thornton moves onto two other approaches to diagnostic validity. One is raised by Kendell and Jabalensky in a recent article (Kendell and Jablensky 2003). Following on a skeptical position regarding the possibility (at least for the present) of making psychiatry etiologically and physiologically scientific, they offer an alternative approach to validity, based on a notion of clear boundaries among the various syndromal diagnoses. Thornton shows some sympathy toward this position but also finds some unclarity in it. He doesn't raise an obvious objection: that one can easily imagine a syndrome that meets the Kendell/Jablensky standard of clear boundaries ("zones of rarity") but has no validity. A recent example of an absurd diagnosis that meets the standard of adequate boundaries from other diagnoses is the proposal to turn jet lag into "jet lag disorder" because a medication is available to lessen the symptom.

A second innovation in diagnosis is the WPA proposal to include a narrative component into ICD diagnoses. Thornton handles this quite well, showing sympathy for the idea, questioning the conceptual limits of particularity even when focusing on the individual, and questioning its contribution to validity. I would add only that, whether in the manual or not, the narrative focus virtually always has a place in clinical practice.

In the final section of this chapter Thornton engages in an extended discussion of "lessons from the philosophy of science" for diagnostic validity. I won't attempt a review of his discussion. Let me say only that the discussion is complex and thorough, and that it leaves us with a sobering appreciation of how complex is the challenge of validity in psychiatric diagnosis.

In the final chapter, "The Relation of Evidence-based Medicine and Tacit Knowledge in Clinical Judgement," Thornton takes up the issue of the currently fashionable evidence-based psychiatry, the application of the evidence-based medicine movement (EBM) to our field. Although he doesn't dwell on the connection, the issue at stake in this chapter is clearly related to that of the previous chapter. A presupposition of evidence-based practice is that we are working with more or less valid diagnostic constructs. Thornton begins with the work of Geddes and Harrison, who frame the definition of evidence-based psychiatry in terms of a hierarchy of evidence, with evidence from meta-analysis of randomized control trials (RTCs) at the top of the hierarchy and expert opinion at the bottom. He quotes the authors to the effect that EBM only "ensures the best use is made of *available* evidence" and that there is ultimately a role for skilled judgment, but notes that that is not the thrust of the article. He then cites the work of Sackett et al, who state in their volume that "Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values," but devote the entire book to research evidence.

Following this introduction to the topic, Thornton moves his discussion to the philosophic assumptions underpinning EBM, specifically the ability to use past experience to predict future events. He does this in the context of of Hume's challenge to induction, as well as to Hume's own response to his skeptical position and Mill's further treatment of induction. Hume's argument, in brief, is that correlations confirmed in the past are, strictly speaking, no guarantee that they will hold in the future. His own response is that it has been human practice, however unwarranted, to make this assumption. For his part Mill offers a defense of induction that - to simplify - is reliant on the factors participating in the inductive process. In the case of EBM, this means the strength and validity of the diagnostic structure that is used in EBM. This leads Thornton back to the previous chapter. If the validity of the diagnoses used in RTCs is weak, then the entire structure of RCTs and EBM is thrown into question.

In the face of these challenges to the inductive process, Thornton mounts a strong argument for the role of clini-

cal judgment at every level of the EBM practice - in designing clinical trials, and especially in applying the general principles of EBM to the individual case. He writes that "Despite that appearance, EBM merely disguises the role of uncodified clinical skill" (221). He insists that clinical judgment cannot be fully codified, and that it is part of the practical or tacit knowledge with which navigate our way through the world. For philosophical support he again invokes Wittgenstein and the latter's argument that following a rule is not a matter of intuition or interpretation but rather of practical know-how. In making statements such as that "...by learning from Wittgenstein's discussion...judgements can be justified by particular circumstances," it remains unclear whether he acknowledges the degree to which clinical judgment remains less than certain and thus defeats the longed-for scientific purity of EBM.

In the conclusion of the volume Thornton reviews three themes that have pervaded the entire study (albeit in each case highlighted more in one chapter than another): the role of judgment, the whole person as the basic unit of meaning in psychiatry and mental health treatment, and the philosophical theme of relaxed naturalism. In a final note on the future of philosophy of psychiatry he predicts future trends such as more emphasis on an embodied theory of mind, more convergence of analytic and phenomenological approaches, a greater emphasis on virtue ethics, and - from the clinical side - a movement toward a human rights approach and toward the recovery model.

In concluding this review I return to the two questions I posed at the beginning. First, Thornton's defining the "new philosophy of psychiatry" as a an enterprise of analytic philosophy leads to an obvious question: how well does analytic philosophy succeed at this self-appointed mission? My answer is: at times well, at times less well. And I would quickly add that, as Thornton acknowledges occasionally, it could only benefit from breaking out of its self-imposed confines. One example is the truncated analysis of meaning that I alluded to above. Another is the (in my opinion) etiolated account of delusion offered by philosophers working in the analytic tradition.

The second question—the more important one—is that of the utility of this work for mental health practice. The author sets the bar rather high in this expectation, and I will quote him once again:

> ...unlike some areas of philosophy, philosophy of psychiatry can have a real impact on practice. It is a philosophy of and for mental health care. It provides tools for critical understanding of contemporary practices, of the assumptions on which mental health care more broadly, and psychiatry more narrowly based, are based. It is an area where philosophical work is carried out by practitioners and services users, as well as professional philosophers (p. 1).

So our question is: does the book fulfill this promise? My answer is a fairly unqualified no. If the book (and philosophy of psychiatry in general) is to have "a real impact on practice," its readership must be presumed to be ordinary practitioners. While I can imagine the occasional practitioner with a strong interest in philosophy putting in the time to work through these chapters, I find it very difficult to imagine the average practitioner making that effort and benefiting from it (the exceptions being the more accessible chapters like those on ethics).

I don't intend this as a criticism of the author but rather as an unmet challenge for all those working in this interdisciplinary field. Most publications in the philosophy of psychiatry are quite technical—whatever the tradition out of which they are written—and expecting them to have an effect on mental health practice is quite unrealistic. In his discussion of Wittgenstein, Thornton asks: "what positive account of mental content and linguistic meaning does Wittgenstein suggest for mental health care?" My answer would be: none. If you really want to influence mental health care with Wittgenstein's account of meaning as use and practice, you will have to get rid of the technical language and translate Wittgenstein's analysis into the language of practitioners, show them, in their language, what might be the implicit philosophic assumptions they are working with, how those don't serve them well, and how your suggestions might lead to better practice. As you can verify in the pages of PPP, this is not something we do well. For an exemplary example of this kind of work, I can point to the effort of Roy Schafer (1976)—ironically, a psychoanalyst, not a philosopher of psychiatry. In a sustained critique of the reified categories of psychoanalytic language, he showed, for instance, that reifying the unconscious leads to abdication of personal responsibility, as in, 'my unconscious made me do it'.

In conclusion, then, while I can readily recommend *Essential Philosophy of Psychiatry* for the community of philosophers and clinicians with a clear interest in philosophy of psychiatry, I have little hope that this book, any more than most of the publications in our field, will have the desired impact on actual mental health care.

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Jaspers Prize 2011

2010-11 marked the revival of a long-established AAPP initiative, the Jaspers Prize, given for the best solely authored, unpublished paper by a resident or student related to the subject of philosophy and psychiatry. Although it had lapsed in the last several years, this prize has proven a valuable source of interest and membership for the organization (past winners have included EC members Nassir Ghaemi and David Brendel, as well as Dan Stein). The award is announced at our AAPP Annual Meeting and this year carried a cash prize of $350 and the essay's publication in the AAPP Bulletin.

This round, our efforts were simplified because notification of the particulars could be circulated electronically: to the directors of psychiatry residency programs, and the American Philosophical Association. With a suggested length (between 4.000-6,000 words), submissions had a deadline of the end of January 2011.

Our AAPP Jaspers Prize committee made its deliberations based on relevance, originality and rigor. It was a strong field, with a half dozen submissions of especially high quality, and the decision was a difficult one. The winning essay was entitled: "Adopting the Psychiatric Stance Mental Illness in Dennettian Context" and was submitted by Dr Ben Lewis. Its sophisticated understanding of philosophical theory and its relevance to both disciplines, as well as its convincing argument, were particularly commended.

Jennifer Radden, D Phil

Adopting the Psychiatric Stance: Mental Illness in Dennettian Context

Benjamin R. Lewis, M.D.

I. Psychiatry and Explanation

Ia. Introduction

This paper aims to how certain elements of Daniel Dennett's philosophical work can be brought to bear on troubling conceptual issues in psychiatric explanation and nosology. While Dennett's work has figured heavily in cognitive and computational neuroscience its influence has not extended significantly into the field of psychiatry. I believe there are several reasons for this. First, even in the current age of biological psychiatry the field is beset by an active array of binaries regarding methods of understanding and explanation that can be broadly classified as scientific vs. humanistic approaches. Inherent in this opposition is a dualism about the brain/mind that is potentially threatened by Dennett's strong naturalism about mental states. Secondly, Dennett's notion of heterophenomenology and the relative devaluation of the metaphysical status and autonomy of first person subjective states (contra Chalmers, Jackson, Nagel) threatens this same binary and can thus be misinterpreted as neglecting the individual in a way that contradicts the long history in philosophy of psychiatry of prioritizing phenomenological approaches (Jaspers). Thirdly, while Dennett is a firm materialist about mental phenomena, his particular brand of nonreductive materialism does not align with the current drive to identify mental illness with underlying neurobiological pathology in a *simple* way contra approaches that are more representationalist in nature. I will argue that none of these objections prevent Dennett's work from coming to bear on issues in the philosophy of psychiatry in a fruitful way. Furthermore, Dennett's particular way of carving up the philosophy of mind can dissolve troubling conceptual issues in the field that are not currently adequately addressed by other philosophical stances and resonates on a practical level with day to day clinical understanding of mental disorder.

I will proceed by first exploring the binaries at play in current psychiatric understanding and then discuss one particularly influential approach to dealing with this divide: Bolton and Hill's work in *Mind, Meaning, and Mental Disorder*. This approach takes a representationalist route that will serve as a nice contrast to Dennett's framework. I will then move on to exploring Dennett's strategy in terms of his concepts of the Intentional Stance and Heterophenomenology. Finally, I will revisit the implications that this discussion has for psychiatric classification and understanding as a whole.

Ib. A Field Divided

Psychiatry is beset by an active array of binaries regarding methods of understanding and explanation. A recent and effective exploration of this longstanding state of affairs is David Brendel's *Healing Psychiatry: The Science/Humanism Divide,* an elegant

work that describes the conflicted relationship between scientific and humanistic methods in understanding mental illness and calls for a pragmatic methodological pluralism of approaches rather than a reduction or an integration. This pluralistic approach is also recently advocated by McHugh and Slavney's *The Perspectives of Psychiatry* in which four explanatory and methodological strategies are described: a) the Disease conception, b) the Dimensional conception, c) the Behavioral conception, and d) the Life Story conception. While these works are correct to advocate for a pluralism of approaches they do not attempt to resolve the question of what the underlying distinctions consist in and of and whether this difference is metaphysical or merely practical: if a combination of methods is indispensable, is this an ontological or a pragmatic necessity? As Dennett pointed out in *Content and Consciousness* "the recognition that there are two levels of explanation gives birth to the burden of relating them, and this is a task not outside the philosopher's province" (Dennett 1969, p 95-96).

The dualism, if you will, in psychiatric conceptualization and methodology has a long history in philosophical debate, perhaps best traced to the *Methodenstreit.* Literally translated as "methodological debate" this term refers to the philosophical discussion during the 19th century as to the nature and status of the 'human sciences' and their relationship to the physical sciences. This subject matter had an enormous influence on Karl Jaspers who continued to develop this notion of a methodological distinction between *causal explanation* and *meaningful understanding* as it relates to psychiatry (Ghaemi 2008). Psychiatry, clearly employing both scientific explanation and human understanding, is at the heart of this dichotomy. The first half, that of causal explanation, when translated for present concerns captures much of modern psychiatry's focus on neurobiological explanation and neuroanatomical substrates for human thought, emotion, and behavior. It favors mechanistic explanation at the level at which the causal action is thought to *do the real work*. The second half, that of meaningful understanding, recognizes that humans operate in a complex meaning-driven phenomenological world that, at least on first glance, is less readily parsed by the scientific method. Many of the objections to the whole-sale embrace of science in psychiatry hinge on variations of this dichotomy- the assumption being that the scientific method as a whole might be well and good for describing dopaminergic neurotransmission in the nucleus accumbens but falls short insofar as shedding light on the complex layers of meanings and intentions involved in an individual's continued drug use and the role that those personal meanings play in his or her psychological economy.

This dichotomy was, in part, the motivation driving Jaspers' defense of a 'subjective psychology' alongside 'objective psychology.' Consider the following quote:

> All such concepts as fatigability, the power of recovery, learning ability, the effects of rest periods, etc., refer to performances that can be measured objectively, and it does not matter whether one is dealing here with a machine, a live but mindless organism, or a human being endowed with a mind (Jaspers 1314).

The fear is that an objective catalogue of brain states, neurophysiological goings-on, and cognitive processing routines will perhaps shed light on the brute mechanics of neural states but will be ineluctably incomplete in providing an understanding of *what it is like* to be in certain mental states. As mentioned in the introduction, the fear in philosophical psychopathology is that this will leave out the subject in an important sense.

A note before going on: while much of the hesitation regarding a full adoption of scientific approaches in psychiatry hinges on the role - or lack thereof - psychodynamic explanations will have in understanding, this paper will not deal with the relevance or specificities of psychological theories so much as the far simpler notion of 'folk psychologies', or rather, the every day, meaning-laden intentional terminology we use to understand ourselves, each other, and our actions. Given that higher-order dynamic explanatory theories rely on these primitive notions of intentionality, belief, desire, wanting, feeling, etc. the explanatory relevance of higher-level psychological theory will depend in large part on how we understand these more basic building blocks. As such, they are a good place to start. As noted elsewhere, the DSM itself can be viewed as a folk taxonomy (Waterman 2008, Flanagan and Blashfield 2000): a "top-down" collection of symptom clusters based on intentional concepts.

Ic. Dealing with the Divide: Bolton and Hill

There are several directions one can take given this dichotomy between *reasons* and *causes*, between the *intentional* and the *subpersonal*. One could opt for the extremes of either an ontological dualism on the one hand (granting full metaphysical and explanatory autonomy to the mental) or an eliminativist materialism on the other (denying any utility or meaningful significance of 'mental' explanations or folk psychological terms given that they reduce to neurobiological goings-on.) One is hard-pressed to find any philosophers or neuroscientists endorsing the first position given its extensive philosophical problems and the burgeoning amount of scientific evidence describing the brain processes underlying cognition[1]. It is difficult to imagine how to reconcile the second position, eliminative materialism as advanced by Paul and Patricia Churchland, with psychiatric approaches and understanding as well as with our common-sense everyday understanding of mental phenomena and the clear utility this understanding has in making our way in the world. As Murphy points out, this position seems to lead ineluctably to Szasz-ian anti-psychiatry positions whereby the notion of 'mental' illness is incoherent given that the dysfunction is cashed out at a lower level of brute physical pathology.

Granting a generic materialism in our thinking about the mental - that mental phenomena are produced by

underlying physical properties and processes - one might still hold fast to these realms being explanatorily distinct: there are phenomena that the physical sciences can explain and phenomena better left to the 'human sciences' and our choice of explanatory strategies is simply a pragmatic one based on what we want to understand**.** Karl Jaspers himself was seemingly noncommittal on whether the distinction between causal explanation and meaningful understanding was ontological in nature or simply epistemological or pragmatic (Fulford 234). To stop here seems unsatisfying. This route could go via reductionist or instrumentalist roads- and its going one way or the other has enormous implications for how we understand psychiatry as well as scientific explanation in general. In other words, if we take seriously the notion that the diverse patterns we see in the world (including mind) are fundamentally reducible to the basic laws of physics without the introduction of radically new emergent properties unpredictable from those basic laws, then higher-level explanation (including here the space of reasons) seems ineluctably second-class and redundant. On the other hand, in holding that scientific theories do not have strict truth values and that science is solely in the business of offering a variety of practical conceptual tools, instrumentalism does not seem well-equipped to deliver us the sorts of psychiatric explanation that we want: namely to reflect an actual and existing process in nature amenable to therapeutic intervention. Even if the explanatory autonomy of the space of reasons does prove to be the case it does not address the philosophical burden laid out by Dennett as to relating the levels of explanation and explaining that difference. Before moving on to Dennett's account I will discuss Bolton and Hill's strategy as a counterpoint.

Bolton and Hill, in their work *Mind, Meaning, and Mental Disorder*, opt for a more aggressive strategy here in undercutting the distinction between *reasons* and *causes* to begin with rather than subsuming one side within the other:

> The split between science and meaning [which twentieth century psychiatry inherited from the *Methodenstreit* through Jaspers] was bound to lead to assault by the one side against the other for excluding it: sympathy with meaning led to outrage against scientific psychiatry, and adherence to science led to contempt for speculations about meaning. This mutual hatred - if that is not too strong a word - was a sign that the split had become intolerable (256).

This redrawing of the lines in the divide is accomplished by arguing that meanings are indeed causes but are not reducible to brute physical facts. The divide is redefined, in a sense, as a distinction between intentional and non-intentional causation. The former, intentional causation applies where phenomena (behavior, action, worldly goings-on) are best explained in terms of information-carrying states insofar as those states have developed in biological systems for functional purposes- namely fulfilling evolutionary goals of survival. A large motivation here for Bolton and Hill is the undeniable explanatory power that intentional-level descriptions carry:

> If you want to explain, for example, how a rat finds its way to the goal box, the answer will involve positing some state of the rat which encodes information about the route to the box. If you want to explain how it moves its leg, then positing a non-intentional process will do: the muscle contracts because of some physico-chemical process. (259)

Bolton and Hill do not stop, however, at simply positing distinctions between explanatory stances, they go on to make an ontological claim: the 'encoding thesis.' This entails that brain states have the unique property of 'encoding meaning' at the same time that they are brute physico-chemical processes. This effectively dissolves the reasons / causes distinction in that brain states are simultaneously physical (and hence causal) states as well as information-carrying; i.e. it allows for a materialist conception of mind that nonetheless provides for the possibility of mental causation.

There are a number of problems here that have been pointed out elsewhere[2] that center on the question of how it is, exactly, the neural states encode meaning and how this is explanatory. Bolton and Hill's resolution of the tension between reasons and causes hinges on supposedly resolving how brute physical goings-on can be intentional or meaningful states. Furthermore, assuming this is possible implies a naturalism about mental properties that undercuts their explanatory autonomy in the first place, raising the problem of epiphenomenalism. Unpacking this last claim, if mental properties are fully reducible to physical states, any causal properties they might have would be redundant and fully explicable by (and realized only through) lower-level physical descriptions.

Bolton and Hill's position can be understood as a representational account of mental phenomena. Broadly speaking, representational accounts of the mind are reductive attempts to explain the content-bearing properties of mental states through lower-level physical properties- that is, to *naturalize* intentionality or explain it in non-intentional terms. Jerry Fodor sums up the project well: "Sooner or later the physicists will complete the catalogue they've been compiling of the ultimate and irreducible properties of things. When they do, the likes of *spin*, *charm*, and *charge* will perhaps appear on their list. But *aboutness* surely won't; intentionality simply doesn't go that deep… If aboutness is real, it must be really something else" (Fodor 1987, 97). In describing brain states as intrinsically 'encoding meaning', Bolton and Hill's project is sympathetic to Fodor's Representational Theory of Mind. Fodor attempts to show how mental representations encode contents by standing in causal relationships with things in the external world that they are about. He does this through positing a 'language of thought' which involves causal manipulations of internal symbols accord-

ing to a system of laws that is able to be mapped onto the rational structure of thoughts. Such an account entails that our folk psychological terms and understanding are simply a reflection of independent mental states and properties existing inside the head. One nice consequence of this approach for Fodor and, by extension, Bolton and Hill is the non-reducibility of the 'special sciences' such as psychology as well as their continuity with the 'natural sciences': given that mental properties are tied to a causal blueprint they track law-like regularities in the world and do so without introducing new ontological baggage. The problem, however, is that to date representational accounts of the mental have not effectively reconciled how semantics are derived from syntax- that is, how brute physical phenomena could actually be *about* anything, how beliefs and other intentional states could actually be *in the brain*. Dennett has a more economical way of dealing with this problem. For Dennett, the notion of 'finding' mental states or meanings in the brain is incoherent: you simply don't have to look that deep.

Before delving into Dennett's account of intentionality a few words should be given to situate his positions within the larger philosophical framework. Like Davidson, (and contrary to representationalists such as Fodor or Bolton and Hill) he resists a reductionistic account of mental states and properties. For Dennett, there are no elements or properties of the brain itself that will strictly correspond with our folk-psychological notions. As such, he keeps the *meaning* versus *causes* distinction very much alive, but does so in a very different sense than we have been discussing thus far. I will look at two areas in Dennett's philosophy- Intentionality and Heterophenomenology - in the hopes of arguing that Dennett's particular nonreductive materialism provides a much more consistent and constructive framework for the methodological pluralism currently advocated in psychiatry. Furthermore, his philosophical position supports scientific approaches to the study of mental illness *across the board*, while avoiding reductionism and maintaining the autonomy of explanations invoking meaning and agency.

II. Dennett's Account

IIa. The Intentional Stance

Dennett's underlying hypothesis regarding mental content is that this content is fixed by adopting "the intentional stance" toward the system for purposes of explanation and prediction- that is, treating it as though it has beliefs, desires, goals in a systematic fashion: "to be a believer is to be explained by the Intentional Stance" ('True Believers' 1987). This position represents a reversal of the traditional view in philosophy of mind: rather than holding that mentalistic interpretation is a byproduct of the fact that there are minds and mental properties Dennett argues that there are mental states and properties simply because we interpret them as such (Seager, in Ross et al p 104). To be an agent simply means that your behavior can be reliably predicted by the intentional stance. As Elton sums up: "intentional states are fixed by sustained patterns of behavior and not by facts about the agent's innards" (Elton 196). Contrasting this with Davidson, Dennett rejects the notion of token physical identities for intentional states. There is no strict identity relation between physical goings-on in the brain and mental states.

The intentional stance is contrasted to other explanatory stances: the physical stance and the design stance. Dennett often uses the chess program analogy to make these differences clear. Consider a chess program and the levels at which its outputs can be explained. On the one hand, we could adopt the physical stance and describe the process in terms of millions of binary operations of 1s and 0s. This would, in principle, yield accurate predictions about the output but to do so would be, as Dennett states "a pointless and Herculean labour" ("Intentional Systems" p 4). Alternatively, we could make predictions as to the chess programs next move by appealing to the Design Stance, namely, the computer program it is following. Provided that the program is functioning as designed, our predictions will turn out to be true. Note that in transitioning from the Physical Stance to the Design Stance our predictions become more economical- faster and easier. However, when playing a chess program to adopt the Design Stance would have no practical application: going through thousands of lines of code would prove too burdensome to make real-time predictions and responses.

Importantly, from this point of view agency (or the space of reasons) can only be discerned from the intentional stance: no matter how elaborate the physical or design stance description they cannot give a full account of agency or meaning. While adopting the intentional stance towards the chess program precludes an exact prediction on the move it will make it does narrow down the range of moves considerably and does so with much less cost than applying the other stances. When prediction fails at the intentional stance it provides rationale for looking at a lower level of explanation: perhaps a bug in the program, a malfunctioning circuit board, or even a power outage.

Based on the successful application of the intentional stance to the chess program it would count as an 'agent' for Dennett- and here is where a number of objections come in. For clearly, there does seem to be a difference between the internal number crunching operations of a chess program and the rich phenomenal inner world of human consciousness. For Dennett, this difference is a matter of degree and our knee-jerk disbelief is more a function of our over-inflated notions of intentionality and consciousness. The underlying motivation here for Dennett is his desire to show how the rich and particularly human varieties of intentionality can be explained as having evolved from simpler and cruder versions in our evolutionary past[3].

Given that, in Dennett's view there is no strict identity relation between mental phenomena and their physical realizers, when you switch stances you also, in a sense switch subject matter:

> [when] we abandon the personal level in a very real sense we abandon the subject matter of pains as well. When we abandon mental process talk for physical process talk we cannot say that the mental process analysis of pain is wrong, for our alternative analysis cannot be an analysis of pain at all, but rather of something else- the motions of human bodies or the organization of the nervous system (CC 94).

However, this does not preclude the intentional stance or 'personal' level from providing a useful "heuristic overlay" (Dennett 1969, p 80) for understanding the sub-personal. When a different stance is adopted for explanation the subject matter of the former stance disappears but one can still label mechanistic elements at the sub-personal level with an eye towards the agent as a whole: the sub-personal components can be labeled with intentional terms in explanatory strategies by virtue of the whole agent.

IIb. Heterophenomenology

As mentioned in the introduction, the study of psychopathology- much as the study of consciousness- is marked by an underlying fear of leaving out the subject. Concerned that something important was left out by objective methodologies in psychiatry, Karl Jaspers coined the notion of 'subjective psychology.' Recent theorists (Bracken 1999, Schwartz and Wiggins 2004, Harre and Gillette 1994, Ratcliffe 2008) have argued for a more rigorous adoption of phenomenological or hermeneutic methodologies in psychiatry but there has not been any specific consensus on what, exactly, this would mean and how it would be carried out- (which is not to say that such attempts would not be fruitful). In philosophy of mind this fear has been expressed as "the Hard Problem" (Chalmers) or in the notion of an "explanatory gap" (Levine). The concern is that while third-person, objective techniques might be just the ticket for studying geology or electromagnetism, these techniques fall well short of the mark in studying first-person subjective phenomena. Dennett disagrees.

Dennett's notion of heterophenomenology is a third-person scientific methodology that aims "to take the first person point of view as seriously as it can be taken" (Dennett 2003 p1). It is a "neutral path leading from objective physical science and its insistence on the third-person point of view, to a method of phenomenological description that can (in principle) do justice to the most private and ineffable subjective experiences, while never abandoning the methodological principles of science (Dennett 1991 p 72). In trying to understand an agent, one starts with "recorded raw data" (ibid 36)- this is made up of a catalogue of the various physical goings-on inside and around the subject as well as the subject's communications (verbal or otherwise) interpreted as speech acts and then (through adopting the intentional stance) interpreted as expressions of belief. In this sense, verbal reports from a subject as to what they are experiencing subjectively are just another data stream, as it were, for interpretation. As Dennett himself points out, this is how the vast majority of neuroscience is actually performed. Dennett is careful to maintain that these interpreted data (convictions, beliefs, attitudes, emotional reactions) are *bracketed* for neutrality. This "has the effect of holding them to an account of *how it seems to them* without judging, for or against, the questions of whether how it seems to them is just how it is" (ibid 39).

> You are *not* authoritative about what is happening in you, but only about what *seems* to be happening in you, and we are giving you total, dictatorial authority over the account of how it seems to you, about *what it is like to be you*. And if you complain that some parts of how it seems to you are ineffable, we heterophenomenologists will grant that too. (1991 p 96-97).

Heterophenomenology aims for a neutral stance that compiles a definitive description of the world according to the subject.

Dennett contrasts this with the notion of auto-phenomenology, or a first person methodology of investigating the contents of consciousness but points out that not only is it hard to imagine such a methodology being scientific but that, importantly, nothing would be gained that could not be appreciated from the third-person stance. Dennett has many critics here (Chalmers, Levine, Searle, Block) who argue that something is indeed left out of such an account: the phenomenal experience of the subject. At this point various thought-experiments come in regarding qualia, zombies, spectrum-inversion- all of which Dennett deals with by systematically cutting our 'inflated' intuitions regarding consciousness down to size and, as such, describing these stumbling blocks as 'chimera.'

The importance here for the study of the mind and for psychiatry is that a third-person scientific stance towards mental phenomena does not leave anything of major importance out. This is in stark contrast with Chalmers or Searle who both argue (to very different ends) for the irreducibility of first-person ontology. Such objections, however, do not translate into clear recommendations on how the objects of consciousness *should*, in fact, be investigated. Rather, they risk inhibiting neuroscientific progress in holding that subjective phenomena are somehow *off-limits* in a fundamental way. For Dennett, on the other hand, there is no need for a separate phenomenological method, or 'subjective psychology' per Jaspers, as objective investigation can reveal everything about the agent that offers pragmatic advantage to know. Importantly, this does not preclude the value of careful phenomenological description and methodology in psychiatry- the catalogue of the phenomenal experience of mental illness- it only allows that scientific methodologies are perfectly adequate for such a task.

This has important ramifications for the distinction in psychiatric understanding between *causes* and *meanings*.

As discussed above, Dennett is non-reductionistic in that he sees the intentional stance as offering autonomous explanation. But this need not imply that it requires an entirely distinct mode of study. Scientific methodologies work well here too- there is no need to develop a radically new 'science of subjectivity' or 'first-person methodology': "the third person methods of the natural sciences suffice to investigate consciousness as completely as any phenomenon in nature can be investigated, without *significant* residue" (Dennett 2005 p 29).

To sum up so far, Dennett provides a non-reductive materialist account of mental phenomena that maintains the need for a methodological pluralism in understanding agents and their actions. He does this by defining intentionality solely in terms of adopting the intentional stance for purposes of explanation. Furthermore, data obtained from agents by adopting the intentional stance takes its place on a continuum with other objective scientific evidence without leaving out anything of fundamental significance. Note the difference here from the representationalist framework given by Bolton and Hill as well as Fodor: these are reductionist accounts that try to tack down mental properties by describing them as representational states in the brain which are then cashed out in non-intentional terms. The way this cashing-out is accomplished, taking into account Dennett's stances, is through identifying mental properties at the design stance level whereby the design stance is understood as a causal blueprint. Dennett claims that you simply don't have to go that deep to explain mental properties: in an important sense, intentional vocabulary (discoverable via the intentional stance) is relevant at lower levels only insofar as it provides a "heuristic overlay" and, hence, is useful for our purposes of reverse-engineering how the brain creates the mind.

III. The Psychiatric Stance

I have attempted to show how Daniel Dennett's views on intentionality can provide a useful framework for the study of mental states in general and psychiatry in particular. I have done so by first examining how the notion of explanation is understood in psychiatry and how that explanation is historically split into the modes of *reasons* and *causes*. I have looked at several recent arguments for methodological pluralism in psychiatry and briefly investigated an alternative standpoint in the philosophy of psychiatry from which this pluralism can be justified: Bolton and Hill's representational framework. I then argued that Daniel Dennett's framework provides a more coherent and pragmatic approach that allows for the nonreducibility of the mental while still supporting objective scientific study of consciousness.

Dennett's account of explanatory stances seems to capture in an important sense how psychiatric explanation operates. When an agent's speech or behavior begins to deviate from norms to an extent that prediction based on the intentional stance begins to fail (and here this stance can imply not just simple folk-psychological notions but also higher-level dynamic explanations that use these basic building blocks) we drop down to a *subpersonal* level to find explanatory power. We might invoke, per design stance perspectives, cognitive architecture and processing dysfunctions to explain the behavior. Or we might resort to biochemical or genetic explanation. Or we might utilize a combination. This pattern nicely tracks how psychiatric explanation has developed historically. The empirical discovery that explanations of psychotic features in patients with paranoid schizophrenia that invoked notions of "schizophrenogenic mothers" or "the bad breast" did not reliably offer practical tools for therapeutic intervention led to alternative explanations invoking dopamine pathways in the mesocortical and mesolimbic pathways, developmental insults, and genetic predispositions. This is not to say that the higher-order pattern of psychotic behavior and cognition is not real, only that explanation that appeals to the intentional stance in this scenario cannot economically or reliably transmit the relevant information *we want to know*, namely, why is this person behaving in this manner? When behavior strays radically outside of our rational norms, interpretation from the intentional stance proves unfruitful.

Psychiatry is full of such examples. The personality changes associated with tertiary syphilis used to be attributed to defects in moral character until the discovery that the explanation that *offered practical advantage* was that they were caused by bacterial infection by *Treponema pallidum*. Parkinson's disease was formally understood as a psychosocial disturbance whereas it is not known to result from pathological changes in the basal ganglia. In each of these cases intentional stance explanations are abandoned for lower-level *subpersonal* explanations for the straightforward reason that there is pragmatic advantage in doing so: it allows reliable prediction of behaviors and symptoms and provides an opening for therapeutic intervention in a meaningful way that directly effects those behaviors and symptoms.

In his work *What is Mental Disorder?* Derek Bolton questions whether mental disorders can be understood as a breakdown of meaningful connections and offers three possibilities. First, he questions whether mental disorders can be understood as the *absence* of meaning but argues that this is too extreme and dismisses many clearly disabling conditions from inclusion given that underlying meaningful patterns can be discerned. Secondly, he posits that mental disorder might be understood as an "absence of meaning on the surface, unperceived by patient, family and clinician" (188) but in further digging this meaning is discovered. Thirdly, he posits that mental disorders might be understood as involving "maladaptive meanings." Notably, for Bolton, (and contra Dennett) these possibilities all assume that meanings are things that exist in the head. Given the heterogeneity of psychiatric kinds it is difficult to know where to go with this framework. It seems to imply a dividing line between disorders where meanings play a clear causal role and those where they don't. When we describe loosen-

ing of associations in a patient with chronic disorganized schizophrenia does it make sense to claim that there are underlying meanings there that we cannot necessarily discern? How to relate this presentation, in light of how we understand mental disorder in general, with that of a borderline personality disordered patient whose dysfunctional self-harm behaviors take place within a clearly meaningful psychological economy? These questions lose a lot of their metaphysical punch if they are reconfigured within Dennett's framework. Meanings, in this case, are a higher-level pattern and our question of whether they are *really there* or not isn't going to be resolved by looking at the brain but in discerning whether the intentional stance offers pragmatic advantage. It leaves it open for empirical discovery whether meanings offer explanatory power in, say, disorganized schizophrenia or catatonia as opposed to social phobia or personality disorders and lessens the perceived pressure of categorizing mental disorders based on the degree to which such explanations apply.

There is no fact-of-the-matter as to which stance is the correct one for explanatory purposes for any given disorder: psychiatric kinds can't be carved up in this fashion. Rather, a given stance- intentional or *subpersonal* (or, for that matter, a *psychoanalytic* stance or *cognitive-behavioral* stance)- is applicable insofar as it offers *pragmatic advantage* to the client and physician/ therapist adopting it, where pragmatic advantage is to be understood as providing reliable prediction and offering potential measurable therapeutic interventions. Note, however, that the degree to which we believe it to reflect truth is a matter of empirical fact- this does argue for explanatory modes that offer testable hypotheses that can be confirmed or disconfirmed (a critique often leveled at psychoanalytic theory). Furthermore, one can switch stances to provide alternative therapeutic modalities. Consider the development of severe major depressive disorder following the death of a spouse. Explanation here obviously appeals to several levels: one can make reliable predictions and therapeutic interventions based on the presupposed levels of monoamines floating in the patient's synapses but to do so without considering the grieving process at the intentional level is to miss out on an important source of information and potential intervention. And this information is *really there* as an autonomous and nonreducible level of causation in the patient's mental economy.

Again, given that for Dennett intentional stance explanations are not fully reducible to physical stance explanations, folk psychology provides an indispensable tool for predicting and explaining our actions and beliefs. This is, I believe, a powerful argument for the potency of psychotherapeutic modalities in understanding and treating mental illness which does not preclude the scientific study of the phenomena in question. Interestingly, it is also a powerful argument in support of Hempel's conception of how early sciences should progress by first developing sets of operationalized categories based on empirical data- that is, through a rigorous and systematic classification of our folk psychological concepts. Such a schema need not wed us to those concepts- folk psychology being notoriously misleading- as there might be other patterns discoverable that offer greater predictive and explanatory power. While we can't make strict law-like causal connections between intentional states and brain states we can "flip-flop" stances to develop hypotheses about physical or design level causes, interpreting those lower level stances with an 'intentional overlay.' In this way, Dennett's views on intentionality support a *pluralist* approach in psychiatry very much aligned with Brendel and McHugh and Slavney.

As has been briefly discussed, Dennett's description of *heterophenomenology* as an approach to studying intentional states has the advantages of both vindicating scientific approaches to mental phenomena while also preserving the autonomy of intentional level explanations rather than reducing them (per Churchland, Szasz) to physical phenomena. This methodology encapsulates what is, in a sense, already being done in psychiatry and the neurosciences. It's explicit formulation in this context however reassures that in the study of subjective states an objective third-person methodology will not leave out anything that would make a meaningful difference. It does not, however, imply that no meaningful data will be obtained through first person or second person methodologies (the former generally invoking introspection or meditation, the latter invoking the concept of empathy) – only that for that data to be used in meaningful explanation it needs to be translated into third-person terms.

This investigation has argued that there are many advantages to be gained by configuring psychiatric explanation within a Dennettian framework. First, Dennett provides a convincing platform for nonreductive materialism about mental states: this has clear advantages in preventing full reductionist or eliminativist explanation in psychiatry and supports current arguments for methodological pluralism. It also offers a powerful argument for both psychotherapeutic and biological modalities in the field (and the inclusion of both approaches within the umbrella of scientific methodologies). Secondly, troubling philosophical puzzles about 'when meaning matters' in the causal explanation of psychiatric disorders can be dissolved if Dennett's framework is adopted. Thirdly, Dennett's notion of explanatory stances resonates with day-to-day clinical practice and nicely tracks how psychiatric explanation has evolved historically.

Endnotes

1. As Jaegwon Kim describes, this position leads to "too many difficulties and paradoxes without compensating explanatory gains." (4)
2. See Fulford p 428, Banner and Thornton 2007, Thornton 1997.
3. As Seager puts it "psychologically characterizable behavior is a fat evolutionary target that Mother Nature would have trouble missing once she

started building organisms of any appreciable complexity" (111).

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(Continued from page 1, Editor)
est group and accepted an invitation to join us in Westport. You can recognize younger versions of some of the still familiar faces in our group.

To complete this look into the past, I have included John Sadler's minutes of the Westport meeting. You can get a sense of AAPP in its formation (including the assignment of this Bulletin to its current editor).

As a footnote to this AAPP history, I can add that in the mid-1980s we had started a philosophy and psychiatry study group at Yale. The initiators were philosophers Maurice Natanson and Edward Casey, psychologist Dan Danielson, and myself. Melvin Woody joined us quickly, and for meetings we took advantage of the geographical proximity of Ozzie Wiggins, Louis Sass, Michael Schwartz, and Aaron Mishara. With the foundation of AAPP we became the first AAPP local study group.

In this issue of the Bulletin John Sadler's minutes of the 1990 are followed by a series of reviews and essay/reviews of recent publications in the field. Publications have certainly outstripped the reviewing process, so here you have only a sampling of some of the best.

Finally, this issue concludes with publication of Ben Lewis' Jaspers Prize paper. As noted by Jennifer Radden, who now chairs the Jaspers Prize committee, we initiated the prize several years to encourage work in the field by young scholars. After a break of several years we are reinitiating the prize . We are very pleased to have Ben Lewis as our recipient, and pleased to be publishing his paper in this issue of the Bulletin.

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