

Association for the Advancement of Philosophy and Psychiatry
Annual Meeting 2014
New York City, May 3-4

Abstracts of (Some) Presentations

Mark Rego: Contingency vs. Treatment-Indication as a Model for Mental Health Practice

Recent currents in mental health research, education and treatment innovations use what I call the “Indication-Treatment Model”. This model uses cross sectional or composite information about a patient’s state and seeks to prescribe an intervention based on this data. In this talk I will describe how this approach is in conflict with how mental health treatment is actually done (called here the “Contingency Model”). The Contingency Model will be described along with comparisons with how it generates and uses data in comparison with the Indication-Treatment model.

Anthony Fernandez and Sarah Wieten: Values-Based Practice and Phenomenological Psychopathology: Implications of Existential Changes in Depression

Values-Based Practice (VBP), developed as a partner theory to Evidence-Based Medicine (EBM), takes into explicit consideration patients’ and clinicians’ values, preferences, concerns and expectations during the clinical encounter in order to make decisions about proper interventions. While we believe that VBP adds an important dimension to the clinician's reasoning and decision making procedures, we argue that it ignores many of the implications that stem from certain psychiatric disorders altering the patient’s capacity to value. Taking depression as our example, and drawing on recent work in phenomenological psychopathology, we argue that cases of severe depression are often characterized by a loss or degradation of the capacity to be affected, both perceptually and emotionally. This loss of affectivity entails a further loss of the capacity to find anything meaningful or significant, limiting the depressed person's capacity for valuing anything at all (whether these be lifestyles, family members, vocations, etc.). Further, patients often lose the typical capacity to transcend their current situation and reinterpret themselves in light of future possibilities. This loss of transcendence results in a loss or degradation of the life narrative whereby one makes sense of oneself and one’s life. VBP takes seriously the importance of life narratives, as well as how such narratives fundamentally shape the patient's values. However, it does not acknowledge the possibility and implications of severe existential changes that degrade the patient’s ability to value, alienating them from their own life narrative. We believe that such possibilities must be accounted for and integrated into the VBP system in order to be effectively applied in cases of clinical decision making regarding patients with severe psychiatric disorders. While such an integration cannot take place in the span of this paper, we follow the above discussion by proposing modifications to the current system of VBP (e.g. proxies, or written statements of value generated by the patient prior to an episode) that would allow it to contend with such cases effectively.

Nathaniel Tailleir: The Spectrum Concept in Research, Clinical, and Public Contexts

One of the most significant shifts currently taking place in psychiatric nosology is the move away from categorical approaches to individual differences and towards more dimensional models. In this presentation I'll examine how researchers and clinicians advocate for dimensional models. By examining the historical antecedents of the categorical/dimensional debate I frame the shift a natural next step in the evolution of psychiatry, a field which is prudently redefining its terms of discourse as a response to the inadequacies of categorical approaches. Drawing on interviews with psychiatrists I discuss how the shift relates to diagnosis, treatment and stigmatization of patients.

Greg Mahr: Narrative Medicine and Clinical Reasoning

The assessment of decision making capacity or competence is commonplace but very complex example of applied clinical reasoning. The tradition approach to the assessment of capacity is based on a model developed by Applebaum. According to the tenets of this model, the patient must demonstrate an understanding of the clinician's model of the clinical situation and the need for the intervention being proposed. To be considered to have capacity the patient must demonstrate an understanding of the relevance and significance of the clinical issues and consistently demonstrate a decision making process and propose an alternative plan. The traditional approach, while thoughtful, clinically useful and respectful of the patient's right to manage his own medical care does not fully acknowledge the complexities of the power relationships involved in medical care. Using the principles of narrative medicine, the author proposes a different model for the assessment of decision making capacity. Narrative medicine asserts, as a matter of principle, that the clinical encounter is multilayered interaction between alternative and equally valid narratives. According to this model, the key elements of the assessment of capacity would involve attempting to grasp the coherence of the patient narrative. As long as the patient narrative was coherent and acknowledged the medical facts, the patient would be considered to have decision making capacity, thus avoiding the conundrum of lending superior authority and credence to the clinician narrative.

Luis Flores: Clinical reasoning in psychiatry: the case for analytical models

Clinical reasoning is here understood as a specialized form of human reasoning. From this perspective, sensible clinical reasoning can be characterized as typically involving (i) the consideration of several sources of evidence, (ii) the advancement of a set of defensible probabilistic hypotheses, and (iii) the use of a coherent system to evaluate and update the plausibility of different hypotheses. Several models have distinguished between hypotheses and evidential sources readily justifiable by explicit logical analysis and those more easily supported by appealing to intuition and non-declarative methods. Likewise, the whole process of clinical reasoning can be represented algorithmically -as an ordered series of inferential steps- or described as a "black box" plus admissible inputs and desirable outputs without further specification. Non-declarative and simplified models of clinical reasoning are able to capture how medical reasoning actually works

but offer little insight regarding the inferential gap between diagnoses and interventions in individual patients. This paper argues that *analytical models* understood as declarative descriptions of the processes by which hypotheses are thought to be relevant in particular cases, and normative standards for updating the probabilities of different hypotheses may help clinicians when they are required to infer the probabilities of several outcomes, specially from diagnostic categories that identify sets of individuals who do not share the same causal structure (i.e.: heterogeneous reference classes). Given that in psychiatric practice clinician's inferences often occur under such complex circumstances, analytical models may offer a comparative advantage over standard alternatives in terms of awareness of the risk of several bias and capacity to detect errors of reasoning.

Emily Barrett: Clinical Implications of Conversational Implicature

How can a clinician adequately reason about diagnostic and treatment options when a psychiatric patient is unable to adequately communicate her experiences of a mental disorder? I argue that Paul Grice's concept of conversational implicature, from Philosophy of Language, has unexpected but significant applications to clinical reasoning because of its bearing on degraded or non-ideal communicative contexts. For conversational implicature to be relevant to clinical reasoning, however, it must be modified to reflect the asymmetrical cognitive capacities between clinicians and patients. In my talk I present these requisite modifications. I also develop a description of clinician-patient communication that promotes dialogue-based (as opposed to interview-based) modes of interaction, which I argue better aid clinicians in the diagnosis and treatment of disorder.

Petra Gelhaus: Phronesis – Basic Skill or Medical Master Virtue?

In medical philosophy, clinical judgment is one of the elementary concepts in order to understand medical practice. Approaching clinical judgment from the perspective of professional virtue ethics, the Aristotelian idea of "phronesis" is closely related to clinical judgment, and Pellegrino attributes the role of the central virtue of a good physician to phronesis. However, in modern virtue ethics, emotional virtues get more attention, and also modern brain research point out the prominent role of emotions in decision-making in contrast to the focus on more rational virtues as phronesis. In my paper, I want to discuss the consequences of these developments for the classical clinical master virtue of phronesis. If emotional virtues and capacities have a central role in decision making – do we need such a strong idea of phronesis at all? I will present some arguments for understanding clinical judgment more as a skill than a virtue, a practical capacity that is not well described as either emotion or cognition, though it necessarily relies on both emotional and cognitive virtues.

Dan Mosely, Gary Gala: Internal Reasons and Clinical Reasoning

Involuntary hospitalization and subsequent psychiatric treatment over objection can be among the most challenging decisions a clinician has to make. We shall focus an influential form of clinical reasoning that is, and should be, used in these activities. Civil commitment and treatment over objection involve difficult decisions about restraining liberty and evaluating foreseeable harms. In these sorts of situations clinical reasoning

should be governed by an ethical framework. What ethical framework should be used to aid in deciding, in particular cases, whether or not a particular individual should be involuntarily hospitalized and treated over objection? To answer this question, we turn to the work of Bernard Williams. His writings have been widely influential in analytical discussions of metaethics and normative ethics. His essay “Internal and External Reasons” inaugurated the important debate about internal and external reasons in metaethics and theories of practical reasoning. We contend that Bernard Williams’ account of internal reasons provides a fruitful framework for conceptualizing clinical reasoning in everyday cases of treatment over objection. We argue that that in the clinical evaluations of patients for involuntary hospitalization or treatment over objection, the clinician who is evaluating the patient often is, and should be, trying to apprehend the patient’s internal reasons for refusing treatment or hospitalization. Thus, our account is both descriptive and normative. To put Williams’ account of internal reasons roughly, whether an agent has a reason to do something depends upon whether there is an appropriate item in that agent’s *subjective motivational set* that is a basis for the agent’s reason. The items in an agent’s subjective motivational set are more than just beliefs and desires. An agent’s subjective motivational set also contains dispositions of evaluation (what we might count as worth our evaluating in the first place), patterns of emotional reaction, personal loyalties and projects embodying central commitments of the agent. When applied to a range of psychiatric cases in which hospitalization or treatment over objection are being considered, Williams’ concepts of internal reasons and subjective motivational sets provide useful tools for clinical decision making. For example, we explain how this methodology justifies the hospitalization of certain delusional patients and emotionally charged suicidal patients. This approach is sensitive to the individual’s longstanding values and is thereby, a patient-centered approach to clinical decision making. This approach also requires clinicians to become familiar with and to take account of the patient’s longstanding values. Williams’ theory of internal reasons contains building blocks that are sufficiently complex and rich enough to explain how momentary and superficial desires of the patient (e.g. the desire to kill oneself) should not be taken as straightforward “reasons” that decisively dictate action. We demonstrate why these momentary desires should not be considered appropriate items of an agent’s subjective motivational set. One controversial implication of our utilization of Williams’ theory of internal reasons for the purposes of clinical decision making is that in certain cases of “rational suicide,” we maintain that there is no justification for involuntary hospitalization or treatment over objection. Specifically, in cases where an agent does not have any internal reasons for hospitalization or treatment, we contend, treatment and hospitalization should not be required.

Phillip Graham, Leo Van Biene: Processes of Clinical Reasoning - The Organisation of Clinical Data in an Intersubjective Space

The aim of this presentation is to demonstrate how an application of John Hughlings Jackson’s “Hierarchy of consciousness” can serve as a map for clinical reasoning in the psychotherapeutic process with people with disturbances in their sense of self. Jackson concluded that the central nervous system could be conceived as being hierarchically structured from evolutionary, morphological, neural and functional perspectives. Indeed consciousness can be conceived of evolving in this manner. This hierarchy can be applied

to the clinical setting, where the movement from lower to higher levels of psychic organization traces an ontological trajectory of expanding consciousness. At its apex a sense of Self is emergent. As described by William James this sense of self is "duplex" in nature and is reflected in a "flow of inner life". These conceptualizations have important developmental and clinical implications. From within this perspective, optimal psychic development unfolds in relation to the provision of an adequately responsive environment, and can be conceived as resulting in sustainable position high in the hierarchy. Compromised development, on the other hand, results as a consequence of an engagement with an adversely responsive environment, and is reflected in a failure to gain or sustain a higher position in the hierarchy. Under these circumstances a sufficiently robust sense of Self fails to emerge and one of the variants of disorders of Self may manifest. The central therapeutic task can be seen as facilitating movement up this hierarchy of consciousness. This movement occurs as a consequence of particular forms of engagement in the relational field between the therapist and the patient. These engagements are matched to the patient's specific reflective and relational capacities and are mediated by specific forms of language. The nature of these engagements shifts in the direction of greater complexity, and they emerge in an epigenetic manner, as one form of engagement provides the precondition for the establishment of the next. Five specific forms of engagement are described. Their unfolding can be observed within in any therapeutic session, as inevitable shifts within the dyad occur, and over the course of the therapy as a whole, where they trace the entirety of a therapeutic trajectory. These relational shifts can be phenomenologically observed and have been verified in linguistic analyses of clinical transcripts. It is our contention that the therapist's understanding of this hierarchy of engagement can be used to develop formulations that inform and enhance the ongoing process of clinical reasoning. These formulations serve multiple functions: in the clinical moment they assist the therapist in making complex choices as to how to respond to the patient in a way that has optimal therapeutic value. And more broadly they serve in constructing a pathway to guide the course of the therapy as a whole. These principles and concepts are based on firm methodological grounds, validated by a body of evidence based research conducted in a large teaching hospital associated with the University of Sydney. They have proven to have pedagogical utility both for psychotherapists in training and the experienced clinician.

Doug Heinrichs: Model-based science and clinical method

A case example will illustrate a theory that views clinical reasoning as model construction. A widely held position in contemporary philosophy of science argues that model construction does the major work in all sciences. (Giere, Cartwright, van Fraassen) From this perspective clinical method is not a poorly characterized "art" that stands apart from scientific aspects of psychiatry, but in fact is scientific method at work. A model-based view also allows for meaningful critique of the quality of any given instance of clinical reasoning and explains how clinical reasoning can be taught.

Mona Gupta, Nancy Potter, Lynne Lohfeld and Simon Goyer: What epistemic weight do psychiatrists place on different types of information used in diagnostic reasoning?

Because there are no laboratory data or imaging results that are diagnostic of mental

illnesses, psychiatrists are obliged to rely on other types of information in order to make diagnoses. In addition to patients' reported symptoms and observed signs, the diagnostic process in psychiatry may draw upon information like intuition, tacit knowledge, empathic knowledge, testimony and critical self-consciousness. In our qualitative study of psychiatric diagnostic interviews, we explore the epistemic weight that psychiatrists place on these kinds of information when engaging in diagnostic reasoning. This presentation will discuss our empirical results in light of the existing literature on clinical reasoning.

Keld Thorgaard: Clinical reasoning as social deliberation

In this paper I will challenge the individualistic model of clinical reasoning. I will argue that sometimes clinical practice is rather machine-like, and information is called to mind and weighed, but the clinician is not just calculating how to use particular means to reach fixed ends. Often the ends are contested. The clinician deliberates together with colleagues and patients if particular means should be used under these circumstances. Deliberation is a public process and is not just taking place in the mind of the individual decision maker. It is a social and dialogical negotiation of the means and ends in clinical practice where the means and ends are formed in this process.

Thomas Cunningham: What is Narrative Medicine? A Deflationary Account for Application to Psychiatry

This paper considers whether narrative evidence based medicine (N-EBM) is a useful theoretical construct for psychiatry. I first describe N-EBM using language used by its proponents. I next argue this account of N-EBM overreaches because it construes narrative as explaining cognitive and affective states of ill persons, as well as communication dynamics between patients, providers, families, and others. I then claim N-EBM cannot coherently do all of this. Rather, I propose that narrative should be understood as directly explicating only communication dynamics. I conclude by suggesting that, nevertheless, N-EBM has significant potential utility for psychiatry, so understood.

Robyn Bluhm, Mona Gupta: Clinical Reasoning - Beyond "Usual Practice"

Evidence-based medicine (EBM), values-based practice (VBP), and patient-centered medicine (PCM) all that claim to improve clinical practice. Each argues that medical practice currently lacks an important dimension and then provides an alternative approach. In this paper, we critically assess each of these three approaches. We will focus on (1) the way that each characterizes the "usual practice" to which it is presented as an alternative; (2) the method(s) it offers for improving clinical reasoning; and (3) how clinicians can know when they have successfully implemented the method.

Laura Guidry-Grimes: Moral reasons for involving mental health users' perspectives in clinical reasoning

I will dissect a claim coming from many psychiatric patients/activists: They care about their mode of being, which constitutes a special mode of flourishing for them. Investigating this claim involves two steps: 1) determining whether the mode of being is valued in the right way, and 2) evaluating whether it is supportive of well-being. Duties

of recognition demand that we take the lived experiences of these individuals seriously in our philosophical formulations of agency and well-being. Through this analysis, I will highlight the ways in which clinical reasoning can be informed by the perspectives and critiques of psychiatrically disabled persons.

Abraham Rudnick: A recovery oriented approach to clinical reasoning about (and with) people who have mental health challenges - a conceptual inquiry

Clinical reasoning such as that involved in diagnosis and treatment planning is fundamental to contemporary psychiatry. A recent development in mental health care is a focus on recovery, both as a set of outcomes (such as symptom alleviation and enhancement of functioning) and as a set of processes (such as having a personally meaningful life and valued social roles). Recovery as a process requires involvement of service users who have mental health challenges in decision making about their mental health care, which contemporary psychiatry has not fully endorsed. In this presentation I will address challenges and opportunities of recovery-oriented clinical reasoning in psychiatry.