Abstracts

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For more information: http://www3.utsouthwestern.edu/aapp/
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SATURDAY, MAY 16, 2015
Westin Harbour Castle Hotel, Harbour A, Convention Level, Toronto, Ontario, Canada

9:30 **OPENING REMARKS**
CLAIRE POUNCEY, AAPP PRESIDENT

9:45 Can RDoc Solve Psychiatry's Crisis of Diagnostic Validity?

Ginger Hoffman and Peter Zachar

One of the clearest signs that psychiatry is undergoing a crisis of confidence was Thomas Insel's (2013) surprising pronouncement on the near-eve of the release of the DSM-5: that the diagnostic categories in the DSM are not *valid*. As a solution, Insel recommended a re-focus away from DSM and towards the NIMH Research Domain Criteria (RDoC) project as 1) a guiding basis for psychiatric research and, presumably 3) an eventual replacement of DSM as a diagnostic system. Once central tenet of RDoC is that "Mental disorders are biological disorders involving brain circuits that implicate specific domains of cognition, emotion, or behavior." (Insel 2013) Thus, instead of studying DSM syndromes like depression and schizophrenia, RDoC focuses on "smaller pieces of the puzzle": basic psychological processes, along with their biological "substrates." RDoC presents a matrix containing rows of such basic psychological processes that are largely borrowed from cognitive neuroscience – including working memory, arousal, reward learning, and perception. And it contains eight columns: genes, molecules, cells, brain circuits, physiology, behavior, self-reports and experimental paradigms. Here, we explore the question of whether RDoC can fulfill its promise in increasing diagnostic validity over DSM, as Insel suspects.

In order to answer this question, we first explore different notions of "validity" in psychology, medicine, and philosophy of science, including: validity as tracking reality, validity as tracking natural kinds, Robins and Guze validity, and construct validity. We argue that the notion of validity relevant to assessing RDoC's promise has not been clearly delineated by its authors. Moreover, even if we assume that RDoC's goal is to specifically increase etiopathological validity, we argue that RDoC faces many challenges in meeting this goal. Specifically, drawing from Craver's work on mechanisms, and the notion of multiple realization in philosophy of mind, we highlight some such challenges, which stem largely from RDoC's difficulties in translating from column to column – for example in translating from observable patient experiences ("self-reports") to brain circuit activity ("circuits"). The relations between columns presumably are not causal mechanisms, but are instead constitutive relations. However, multiple realization and multilinearity vastly complicate the ability to translate between columns on this constitutive picture.

Work Cited

Insel, T. (2013). Directors Blog: Transforming Diagnosis. http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml (retrieved October 15, 2014)

10:15 Developmental Mismatches and Dysfunctional Mechanisms: A Novel Critique of the Harmful Dysfunction Analysis of Mental Disorders

Justin Garson

What is a mental disorder? One well-known, but controversial, definition comes from Jerome Wakefield (1992; also see Nesse 2007). In his view, to say that something is a disorder means that it is a "harmful dysfunction." He explicates "function," in turn, in terms of evolutionary history: the function of a trait is the effect that it was selected for, by natural selection. Hence, his definition attempts to ground psychiatric reasoning within a biological context. Moreover, his analysis opens a door for discussion between philosophers of psychiatry and philosophers of biology.

One well-known criticism of Wakefield's view is the "evolutionary mismatch" critique. Isn't it possible, argue his detractors, that certain *bona fide* mental disorders may have had some fitness advantage in our common Pleistocene environment (e.g., Nesse and Williams 1994; Murphy and Stich 2000)? For example, some researchers have speculated that major depressive episodes may have assisted our Pleistocene ancestors in various ways, for example, by causing them to retreat in the context of male-to-male conflict. The point here is neither that such conditions are advantageous today, nor that such hypotheses are even correct. Rather, the very fact that we can develop coherent and even plausible hypotheses along these lines shows that Wakefield's definition may fail as a conceptual analysis and as a framework for productive psychiatric theorizing.

In the following, I develop this critique in a novel direction by suggesting that, just as certain mental disorders might represent "evolutionary" mismatches, so too might certain mental disorders represent "developmental" mismatches. In other words, certain mental disorders may represent ontogenetic adaptations to challenges inherent in early developmental or formative environments, challenges that no longer obtain in the mature environment. By way of illustration, consider the members of the crustacean genus *Daphnia*, which famously use chemical cues to extract information about the presence of predators, and change their morphology as a result. Suppose an individual member of this genus develops the "helmet" phenotype as a result of chemical cues from predators, and shortly afterwards, the predators are all removed from its habitat. This represents a developmental "mismatch" between the trait and its environment.

I'll develop the initial plausibility of this view by providing an example of a developmental mismatch that may be relevant to psychiatric disorders. Here, I draw on research by developmental biologist Peter Gluckman and others on prenatal and postnatal stress in mammals, and on the work of Viviette Glover and others on the relation between prenatal stress and certain psychiatric problems in children (e.g., Gluckman et al 2009; Glover 2011). According to this viewpoint, disorders such as conduct disorder, anxiety, and even ADHD may be adaptations, that is, expressions of developmental plasticity, rather than "dysfunctions" (where dysfunction is construed in an evolutionary sense). Specifically, they may represent "predictive adaptive responses," developed prenatally or in early postnatal life to adapt the individual to potentially hostile environments (e.g., as signaled by *in utero* cortisol exposure). This process may eventuate in a developmental mismatch: a phenotype that is mismatched to its mature environment.

My point here is not that the developmental mismatch account is correct. Additionally, I realize that we must be wary of the "epigenetics blame game" and sensitive to the social consequences of research into the developmental precursors of mental health (Richardson et al. 2014). My point is that the mere plausibility of the hypothesis that certain mental disorders represent the outcome of such developmental "mismatches" undermines the harmful dysfunction analysis. It shows that the harmful dysfunction account fails as an *analysis* of "mental disorder," and that it is potentially counterproductive as a framework for psychiatric reasoning.

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10:45 The Risk of the Risk of Psychiatric Categorization

Nick Harrison

Recently, actor Angelina Joie underwent a double mastectomy because she understood herself to be at an unusually high risk for breast cancer. Decisions like this demonstrate that knowledge of risk often affects the way we behave. This is not surprising, but it motivates a distinction between two types of medical categorization: *diagnostic* and *non-diagnostic*. Diagnostic categorization is when a patient is labeled with a known disorder. I take known disorder simply to be an established diagnosis. Non-diagnostic categorization, on the other hand, is when a patient is placed at the periphery of a diagnosis due to her risk of the disorder. In cases like Jolie's, it seems unproblematic that a patient be told of her risk and allowed, perhaps encouraged, to make relevant decisions based on the information. I argue, however, that in cases of non-diagnostic *psychiatric* categorization the picture is not always so clear. In fact a patient's knowledge of her risk for certain psychiatric diagnoses can often do more harm than good, for the patient, the populations to which they belong, and the very concept of evidence in psychiatry.

Drawing on Hacking's "making people" project, I show how heritability and other characterizations of psychiatric categories lead to "at risk" categories. These present significant ethical and epistemic problems for psychiatry. Namely, as a result of a patient's recognition of their greater than average risk for psychiatric classification, the patient is non-diagnostically categorized. Depending on the disorder, this can put the patient at greater risk of diagnosis by influencing their self-conception and behavior in harmful ways. The slide from non-diagnostic to diagnostic categorization poses an ethical problem for clinicians because in cases like Jolie's we think that understanding risk will benefit the patient, and in some cases it will. So in some cases non-diagnostically categorizing may be beneficial. How to discern the cases in which knowledge of risk would be beneficial and those in which it would be harmful is an ethical challenge for clinicians.

Relatedly, as the slide from "at-risk" categorization to diagnoses continues there is a more global problem. Psychiatric screening at present lacks robust sensitivity to Type I and Type II error. As a result, all positives are treated as true positive and therefore constitute the prevalence of a given disorder in a population. If each patient who is non-diagnostically categorized is more likely to be subsequently diagnosed, then these cases will increase the prevalence discernably. As these cases add up, the prevalence of the disorder will rise and with it the credence of clinicians that any given at-risk patient warrants a diagnosis. This pattern of justification feeds back on itself and the prevalence of the disorder continues to rise.

This is not merely an academic problem. The prevalence of psychiatric disorders is used to create policies that target at risk populations. The most significant upshot of my position is not only should prevalence not be used to form these policies because it is epistemically dubious, but targeting populations that are at risk for particular disorders will serve to exacerbate the problem it is supposed to mitigate.

11:15 Predicting Posttraumatic Growth

Ami Harbin

This paper introduces questions in psychiatric ethics regarding the growing field of psychological research into 'posttraumatic growth'. There is a substantial literature in clinical psychology on resilience, hardiness, and coping in the aftermath of traumatic events. A team at the University of North Carolina at Charlotte has developed a research program specifically into 'posttraumatic growth' using the term to describe how, after devastating experiences (e.g., death of loved ones, serious illness, natural disasters), individuals can come to feel that they have gained purpose, understanding, or clearer priorities. Tedeschi and Calhoun (1996, 2004) have specified five ways in which they have found posttraumatic growth occurs, and recently (2013) outlined corresponding strategies for clinicians. The field of posttraumatic growth research is now substantial, with researchers applying the concept in various domains (see selected references).

Elsewhere, I have considered the clinical implications of this research, raising ethical concerns about 'growth-oriented clinical practice'. In this paper, I focus on some of the methodological and epistemic complexities of conducting research into posttraumatic growth. I will begin by examining the methods that have informed research into posttraumatic growth so far, before highlighting four problems with such research: two problems with how growth is defined and two further with how it is measured.

(1) Definition of growth: assumptions about positive vs. negative experiences, and individualism

The empirical work on posttraumatic growth is informed by understandings of 'growth' that require further consideration. First, there is typically a dichotomy implicit in studies of posttraumatic growth: some posttraumatic experiences are typically interpreted as *positive* (e.g., closer relationships with family members), while others are interpreted as *negative* (e.g., alienation from family members). Such a dichotomy informs the way studies are designed, what participants are recruited, what interview or survey questions are asked, and how participant responses are interpreted. I will argue that these implicit assumptions about the definition of growth are unjustified and limit the research.

Further, the growth that is investigated is typically assumed to be growth of and for the traumatized individual *herself*. The question of how such events change relationships, communities, or moral action more broadly is secondary, or not considered at all. I will explore the possibilities for a conception of growth that extends beyond the individual.

(2) Measurements of growth: interpretive limitations and dominant narratives

Research into posttraumatic experience is challenging, especially as individuals often have some inclination to make meaning of their own experiences as having had significance beyond the hardship, and study participants are sometimes also the patients of clinical researchers. I will raise two major concerns about the methodologies of this research.

First, the research is designed in a way that only allows for confirming the existing account of growth. Participants either confirm that they have grown in one of the five specified domains, or they are characterized as *not having grown*. The analysis can easily allow for the fact that not everyone grows as a result of trauma – the project is not to show that growth occurs in a majority of cases, only that it does occur sometimes in the specified senses. I will argue that this way of designing the research limits what patients can express in research/clinical encounters, and precludes expanding or correcting the understanding of growth that informs the analysis.

Second, the research does not allow for critically reflecting on the participants'' self-understanding can be influenced by culturally dominant understandings of recover (e.g., 'what doesn't kill me makes me stronger'). I argue that research into posttraumatic growth should give resources for understanding the potential harmful impact of such dominant discourses, and suggest ways such research might be developed.

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11:45 LUNCH

1:30 Cross-Cultural Research, The Naturalness of Mental Disorders, and Culture-Bound Syndromes

Jonathan Tsou

In this paper, I argue that cross-cultural research on psychopathology provides a particularly fruitful resource that can be utilized to address the question of 'how natural' mental disorders are. I articulate this argument with reference to cross-cultural research on schizophrenia, depression, and anxiety disorders. Cross-cultural research on mental disorders has indicated that the symptoms of certain disorders (e.g., schizophrenia) are expressed more uniformly across cultures than the symptoms other disorders (e.g., major depression), which are subject to greater cultural variance (e.g., the symptoms of depression in China are expressed more in terms of somatic complaints than in Western cultures). On the basis of these findings, I argue that disorders whose signs are expressed more uniformly across cultures (e.g., schizophrenia, bipolar disorder) are ‘more natural’ insofar as their signs are *more directly constituted by a set of stable biological mechanisms*. By contrast, disorders whose characteristic signs are expressed with greater variability across cultures (and time) are ‘more artificial’ insofar as the expression of these disorders are more strongly influenced by social factors—such as social norms, mechanisms of role-adoption, and social feedback effects (i.e., looping effects). This perspective offers a framework for addressing longstanding issues in the philosophy of psychiatry literature concerning the extent that biological (natural) and social (artificial) factors contribute to the expression of disorders. It also suggests an answer to the question of whether and when mental disorders should be regarded as natural kinds. According to the analysis of the paper, disorders whose signs are more directly determined by a set of stable biological mechanisms (e.g., schizophrenia, bipolar disorder obsessive-compulsive disorder) are natural kinds, whereas disorders whose signs are more strongly determined by social mechanisms (e.g., hysteria, narcissistic disorder) are artificial kinds. In this framework, the distinction between natural kinds and artificial kinds is best understood as a distinction of degree, rather than a sharp distinction in kind. Moreover, the relative uniformity of expression of disorders across cultures provides a measure of ‘how natural’ a mental disorder is. In the final section of the paper, I explore what this framework suggests about the ‘reality’ of culture-bound syndromes, focusing on culture-bound syndromes related to anxiety (e.g., *ataque de nervios*). I subsequently examine more general questions concerning how these syndromes should be classified by a diagnostic manual such as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). I conclude that culture-bound syndromes should not be understood as distinct disorders (or kinds), and these syndromes are better understood as instantiations of a more general disorder (e.g., panic disorder, generalized anxiety) whose expression is mediated by a particular cultural context. With respect to the classification of disorders, this perspective provides a justification for abolishing the DSM-IV’s classification of culture-bound syndromes as distinct disorders, and integrating these cultural variations into more general diagnostic categories. The basis for this argument is that if the DSM aims to provide projectable diagnostic categories that yield reliable predictions about the prognosis or treatability of particular disorders, it ought to focus on individuating disorders at a level of specificity that captures the common biological causal structure shared by members of a kind, as opposed to individuating disorders whose signs reflect particular cultural differences.

2:00 Mental Illness, Freedom, and Development

Jeff Bedrick

A number of studies have shown that some psychiatric illnesses, though not all, are more prevalent in the United States, Western Europe, and other highly developed countries than they are in the less developed countries of the world. This is at times written off as being due to higher rates of diagnosis in the developed countries, but this does not explain why this finding is also seen in carefully designed international studies that set out to look for the incidence of different diagnoses using standardized instruments, and that do not rely on diagnoses made in the course of routine practice in the various countries in the studies. The finding is sometimes assumed to be an example of so-called “first world Problems,” with the implication that in countries where basic needs are not as easily met, people do not have the “luxury” of having these lesser psychiatric illness, which are thought of as the province of the "worried well." It is not clear how to reconcile this with the higher rates of illnesses such as major depression or anorexia that are associated with significant morbidity and even mortality. (Though it is often thought that anorexia is an illness that doesn't exist where people may have to struggle with true scarcity and hunger.) These illnesses do not seem to represent the excessive worries of those who are otherwise well. More recent work, work that has taken the questions raised more seriously, has suggested that social and economic inequality may account for these differences (The Spirit Level). I will argue that while this line of reasoning comes closer to dealing with the issues involved, it is still inadequate, though it points to part of the answer. It does not, however, for example, explain why inequality is linked to psychiatric illness, rather than to higher rates of crime or of social rebellion. In the balance of the paper I argue that in offering greater freedom and possibilities than are available in less developed and more traditional societies, that the developed world also offers more ways in which people's lives and projects can go wrong. I further argue, based on my earlier work on mental illnesses as disorders of freedom, that is, as illnesses that impair human freedom in certain specific ways, that some of the ways in which people's lives and projects can go wrong in the developed world result in the sorts of impairment that manifest as mental, or psychiatric, illnesses. The higher rates of certain mental illness that are found in the developed world thus point to an expansion of human freedom as well as to its possible pathologies. A brief conclusion sketches some ways in which disorders of freedom might be minimized while still maximizing the freedom and opportunities socially available.

2:30 The Logic of the Broken

Robyn Gaier

Illogical thinking is often correlated with depression as a mental illness.[1] As such, it is believed that the discipline of philosophy – specifically, the study of argumentation and the identification of fallacies – may aid those suffering from depression.[2] In this paper, however, I argue that the appearance of illogical thinking in someone suffering from depression may be precisely that – an appearance. Nevertheless, I maintain that the discipline of philosophy still has a significant contribution to make in the study of the thought processes of those suffering from depression. Specifically, at a more fundamental level, philosophical analysis of what constitutes rational agency may inform the study of depression.

In the first part of my paper, I clarify that I am focused upon depression as a mental illness, rather than depression as it is naturally experienced in the course of everyday life. I then proceed to examine the ways in which thinking may be deemed illogical, and I separate the notion of 'illogical' from other, similar characterizations of thought processes, such as: irrational and unreasonable. In the second part of my paper, I draw upon the study of (first-personal) narratives in effort to show that one's self-conception underlies one's thought processes. Alterations in one's self-conception, as well as holding an inaccurate self-conception, impacts one's thoughts and behaviors and may explain the appearance of the illogical thinking patterns commonly attributed to suffers of depression. I suggest that the attribution of illogical

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[1] See, for instance, David D. Burns' *Feeling Good: The New Mood Therapy*. New York: HarperCollins Publishers, 1980, esp. pp. 32-49, as well as Aaron T. Beck and Brad A. Alford's *Depression: Causes and Treatment*. 2nd Ed. Philadelphia: University of Pennsylvania Press, 2009, esp. p. 258.

[2] See, especially, William Irwin and Gregory Bassham's "Depression, Informal Fallacies, and Cognitive Therapy: The Critical Thinking Cure?" *Inquiry: Critical Thinking across the Disciplines*. Vol. 21. No. 3. (2003): pp. 15-21.

thinking to sufferers of depression is misguided because it fails to consider the integral role of one's self-conception in the construction of a rational agent's reasoning processes.

To support my suggestion, I draw an analogy between the appearance of illogical thinking in someone suffering from depression and the appearance of a lack of empathy in someone suffering from autism. While those at a certain level on the autism spectrum may appear to lack empathy, it is misguided to suggest that such persons actually lack the capacity to empathize. There is much in the relevant literature to suggest that a degree of social impairment is underlying the appearance of a lack of empathy among persons with autism.[3] The inability (or the impairment of one's ability) to 'read' social cues and to interpret non-verbal communication makes it difficult to relate to the emotional life of another person and, hence, it becomes difficult to know *when* to empathize. But that is not to say that someone experiencing such social impairment lacks the capacity for empathy. In a similar vein, having a fragmented self-conception will impact one's thought processes. But that is not to say that someone who holds such a fragmented self-conception will thereby reason illogically.

My project is significant for several reasons. First, it furthers an understanding of depression as a mental illness, since I maintain that sometimes illogical thinking may be appropriately attributed to persons experiencing depression that is not an illness. Second, by suggesting that illogical thinking is only an appearance and, hence, ought not to be attributed to sufferers of depression, one upshot of my project is that it may reduce the social stigma associated with depression as an illness. Third, I am hopeful that my project may have implications for the treatment of depression. Fourth, my project still supports the view that the discipline of philosophy may make an important contribution to the psychological analysis of depression by drawing upon the notion of agency and examining the impact of one's self-conception upon an agent's rational thought processes. Therefore, the philosophical contribution I suggest resides at a more fundamental level than previously supposed.

3:00 Kant's Head Maladies

Elizabeth Robinson

In a rather short pre-critical work entitled *Essay on the Maladies of the Head*, Kant lays out a classification system of the various ills he believes can afflict an individual's mind. The taxonomy of maladies is interesting for any number of reasons. It is a fine example of a characteristic form of snarkiness Kant usually reserves for those whose beliefs are tainted with superstition. Though it presents only one particular eighteenth century take on the varieties of mental illness, it is likely to be typical of thought at the time. It gives us a sense of the way in which Kant ranks the merits of various cognitive capacities. Most interestingly, however, I argue that it provides an entryway into understanding why it is that philosophers have not paid mental illness nearly the attention it deserves.

Kant begins that essay by claiming he will follow the lead of the physician in offering a name to all the various way sin which one might experience "frailties of the head." He begins with minor infirmities

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[3] See, for example, Jeanette Kennett's "Autism, Empathy and Moral Agency," *The Philosophical Quarterly*. Vol. 52, No. 208 (2002): pp. 340-57, as well as Victoria McGeer's "Varieties of Moral Agency: Lessons from Autism (and Psychopathy)," in *Moral Psychology, Vol. 3: The Neuroscience of Morality: Emotion, Brain Disorders, and Development*, Walter Sinnott-Armstrong, ed. (Cambridge: The Massachusetts Institute of Technology Press, 2008) pp. 227-57.

(dull headedness, idiocy, foolishness) and moves towards the more serious (insanity, craziness, dementia), discussing the important characteristics of each in turn. Kant ends by reminding the reader that he has not given any indication of the root causes of these frailties, only their expression or symptoms. While Kant does make a kind of separation between those maladies which are "despised and scoffed at" and those "which one generally looks upon with pity", taken as a whole the various maladies represent a spectrum from bad to worse, rather than distinct kinds of maladies with distinct causes.

The result of this classification system is that even the more serious maladies which lead us to pity rather than despise the bearer of them are understood as yet another form of decreased, diminished or otherwise impaired cognitive capacities. The "fanatic" does not exhibit a distinct kind of reasoning, one that supports his or her fanaticism, but traditional reasoning in a diminished capacity. The fanatic's reasoning is reduced in much the same manner that the dullard or fool's reasoning is reduced, but to a greater degree. If all persons suffering from mental maladies are simply persons with diminished reasoning powers we should take no more notice of them, their personhood or their opinions than we would of idiots. Mental illness is just a stronger form of being stupid or dull headed.

In this paper I argue that the view Kant presents is not his alone, but represents a kind of thinking that has been common throughout the history of philosophy: psychiatry has nothing to offer philosophy because persons with manic depression, bi-polar disorder, schizophrenia, etc. are simply persons in advanced or more pronounced states of foolishness. I argue that this view is not only detrimental to the personhood and autonomy of persons with mental illnesses, but that it has damaged philosophical thinking as well. By viewing mental illness as nothing more than a severe instance of diminished capacity for thought, philosophers have neglected many of the important issues that mind-affecting illnesses raise.

Edwin Wallace IV Lectureship in the Philosophy of Psychiatry and Psychoanalysis

3:45 Personality as Equilibrium: Fragility and Plasticity in (Inter-)Personal Identity

John Russon

What is the "fabric" of human life? The human is a living process of inhabiting a shared world of moral striving, aesthetic contemplation, political exploitation, erotic passion, and so on, and this process is enacted in and as inherently human relationships and practices. The understanding of this existential fabric requires distinctive interpretive categories if it is not to be misrepresented. Taking my orientation largely from the philosophical insights of John Dewey and Maurice Merleau-Ponty, I will argue that this distinctive human identity should be understood as a sort of "system" of establishing equilibrium with the environment, and, in particular, with a human environment.

This notion of personality as equilibrium is highly resonant with central insights from Aristotle's philosophy. Long ago, Aristotle described the distinctive ontological character of human life as a "second nature," which he understood specifically as the virtues (or vices) of character. Humans are such, Aristotle argued, that the fulfillment of their nature does not happen "by nature," that is, it does not transpire "automatically," so to speak, but requires their constitutive input: our own nature has to be "made" by us—a "second" nature. We have a hand in the realizing of our own nature—and, for that reason, the successful realization is not guaranteed. How we cultivate the capacities that come to us “by nature” will determine the extent to which we do or do not realize the humanity that is both our potentiality and the norm to which we are answerable. I will argue that what Aristotle in this context called “the mean”—the characteristic that defines the healthy realization of our capacities—is in fact an excellent model for understanding the “end” of our development; I will argue, that is, that the first demand on our nature is that we cultivate a “mean” state in our relationship with our environment.

Drawing on this basic model of environmental equilibrium, I will address specifically our distinctive experience of self-consciousness—the “I”—that is definitive of human experience. Drawing on R.D. Laing’s notion of “ontological security,” I will argue that self-consciousness is itself a “virtue” in the Aristotelian sense, that is, it is incumbent for our healthy development that we develop a “mean” state in establishing an equilibrium with our intersubjective environment.

Finally, I will consider what practices are required to accomplish the intersubjective equilibrium that constitutes a healthy sense of “I.” I will argue that the establishment of such a “mean” state is a collective accomplishment in which we depend upon the support of others, and thus we are essentially vulnerable to others in our pursuit of psychological health. Drawing on D.W. Winnicott’s notion of “the world in small doses,” I will conclude with a discussion of the essential importance of the notion of “home,” and I will consider broadly the characteristics a home-environment must possess if it is to foster the development of a healthy sense of self-consciousness.

SUNDAY, MAY 17, 2015
Westin Harbour Castle Hotel, Harbour A, Convention Level, Toronto, Ontario, Canada

8:30 Intersubjectivity in Clinical Practice

Joe Burley

Intersubjectivity is an evolving philosophical and neurobiological phenomenon which has important implications for our understanding of psychiatric disorder and psychiatric practice.

Much of the present literature concerning the diagnosis and management of psychiatric illness assumes a Cartesian understanding of the person as an isolated mind within an isolated body with no mention of development of an embodied self, created by interaction and embeddedness in a world shared with others. Consequently our methods of assessment and therapeutic interaction with patients do not include adequate consdieration of intersubjectivity.

In his discussion of Merleau-Ponty's subjectivity, Eric Matthews states "Perception or experience, Merleau-Ponty is saying, is not passive awareness of objects distinct from ourselves, but the active involvement of our whole being, as embodied subjects, with the world around us. Because of that, it is not something which takes place 'within consciousness', but something which expresses our relation as whole (embodied) human beings to objects, and in that sense 'takes place in the world'. Also because of that, the significance that we find in our situation is not something purely intellectual or conceptual, but something which springs from our whole nature as embodied beings. Conversely, the intentionality, or directedness towards objects, which phenomenologists speak of as an essential feature of consciousness, is a relation, not just between 'consciousness' and its objects, but between our whole being as embodied creatures and the world in which we have our being." (1)

This paper will address some basic definitions of intersubjectivity including Gallagher's discussion of 'interactive theory of mind' where he refers to "primary and
secondary intersubjectivity. Primary intersubjectivity (which makes its appearance early in infancy, starting at birth) includes some basic sensory-motor capacities that motivate a complex interaction between the child and others. Secondary intersubjectivity (which begins to develop around 1 year of age) is based on the development of joint attention, and motivates contextual engagement, and acting with others. The third component of IT is narrative competency (which begins to develop around 2–4 years), and involves narrative practices that capture intersubjective interactions, motives, and reasons." (2)

Accepting these phenomena as realities would require that we learn how to attend to the intersubjective system (Stolorow) (3) and learn with our patients how it influences our communicatio and understanding of subjective worlds of both the patient and the clinician. We will examine some of the ways that we are inevitably affected by intersubjectivity (both pre-reflective and reflective) in the clinical setting. We will discuss how an intersubjective approach would affect our interactions with patients (i.e. Schizophrenia, autism, borderline personality disorder) who may have deficits or distortions in their primary and/or secondary intersubjective abilities and experiences. We will also discuss how intersubjective experiences might influence our understanding and experience of empathy and the therapeutic alliance. Finally, we will briefly examine how acknowledging the intersubjective milieu might affect interpersonal boundaries and the sense of personal autonomy and space in the clinical setting.

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9:00 Suggestion, Psychoanalysis, and the Enactive Mind

Karl Loszak

Whenever I mention to a fellow psychiatrist that I am studying philosophy, the usual response is ‘That’s really interesting but … how does it relate to your work?’ Herewith I attempt an answer. Studying philosophy of mind and the history and philosophy of science reveals interesting and productive links with psychoanalysis. I propose to weave together three threads: the role of suggestion in the history of psychiatry, the trend towards intersubjectivity within psychoanalysis, and the enactive model of mind within philosophy of mind.

Suggestion is nothing new. In 18th century France, the Académie des Sciences rejected Mesmer's magnetism, attributing his results to the 'imagination.' Convinced of the power of magnetic fluid, Mesmer nonetheless recognized rapport as an essential element in his method. In 1814, the Portuguese priest Abbe Faria was one of the first to identify suggestion as the active ingredient in magnetism. We know that Freud was frightened off suggestion by Breuer's experience with Anna O. Soon transference brought by the patient replaced suggestion supplied by the doctor. Ferenczi was the first to recognize the utter symmetry of transference, and of suggestion. Melanie Klein had a profound appreciation of the mingling of minds inevitable in intimate relationships.

It is no accident therefore, that recent psychoanalytic theorists of intersubjectivity find inspiration in the writings of the man from Budapest, as well as in updated Kleinian notions of projective identification. Nowadays, we tend to hear more about countertransference enactments than only about transference. It is recognized that every therapeutic dyad is a unique co-construction of the two participants. One approaches such a relationship less as an archaeologist engaged in digging, and more as a long-distance swimmer in a sea of two minds.

Within psychoanalysis, the representational world of self and object is giving way to a more dynamic view of interacting subjectivities. Similarly in philosophy of mind, computational and representational models of mind are being questioned; efforts are made to reunite body and mind, subject and object. Minds are increasingly recognized as embedded, embodied, extended, and enactive. On such views, mind is fundamentally dynamic and interactive. Autonomy and meaning making are essential features of mind. Mind is thus revealed, not in isolation through static structures and representations, but rather in behaviour over time and in dynamic interaction with the surround.

Suggestion, I argue, is an old concept that fits well into a new model. Suggestion hints at the myriad ways in which minds affect one another: intentional and unintentional, verbally and non-verbally, consciously and unconsciously. In my daily work, immersed in other minds, I see suggestion at work in dynamic interaction between two minds. And thus, I suggest to my querulous colleague, my understanding of the history of our field, and of contemporary views within philosophy of mind deepens my understanding of our daily work.

9:30 Rethinking Evidence: The Epistemic and Ethical Dimensions of Good Diagnostic Reasoning

Simon Goyer, Mona Gupta, Lynn Lohfeld, and Nancy Potter

In most areas of medicine, the physician's primary task is to emit correct diagnoses of patient's problems. Ordinarily this is done by correlating information derived from the patient's history of illness with additional evidence such as physical exam results, and the results of laboratory investigations and diagnostic imaging, in order to come to a reasoned conclusion about the right diagnosis. Psychiatrists cannot proceed this way because there are no physical exam findings or test results that measure the pathology involved in mental illnesses. In most situations they make diagnoses by comparing elements from the patient's history of illness to sets of operationalized criteria (e.g. DSM criteria). In the absence of objective measures of disease it is more difficult to claim that psychiatric diagnoses are right or wrong. Thus, diagnoses in psychiatry are less like the right answer to a puzzle as they are in other areas of medicine. Instead, they act more like a roadmap; orienting clinicians towards ways of helping patients address their problems. Psychiatric diagnostic reasoning is good to the extent that it facilitates this goal. This stands in contrast to diagnostic reasoning in other areas of medicine, where a judgment of whether diagnostic reasoning has been good is independent of whether or not it helps the patient.

We hypothesize that good psychiatric reasoning requires psychiatrists to go beyond accepted forms of diagnostic evidence such as patients' reported symptoms and objective clinical observations in order to draw upon additional processes such as: 1. tacit knowing; 2. empathic knowing; 3. weighing testimony; 4. mapping clinical data onto theory; 5. relational knowing; and 6. critical self-consciousness. To investigate this hypothesis, we explored qualitatively the epistemic weight that psychiatrists place on these ways of knowing when engaged in diagnostic reasoning. We recruited 16 volunteers (practicing psychiatrists) who each engaged in an observed, diagnostic interview with an actor trained to serve as a simulated patient in one of three clinical scenarios. The first scenario required the psychiatrist to weigh the patient's story against a contradictory account gleaned from the testimony of his mother. The second scenario required the psychiatrist to weight the patient's story against contradictory laboratory results. In the third scenario, the psychiatrist interviewed a patient who was potentially difficult to deal with: demanding, impulsive, and immature. This scenario was designed to mobilize the volunteer's own feelings towards the patient as a potential diagnostic tool. The clinical encounters were followed by an interview with each participating psychiatrist in which we tried to understand from his or her point of view if and when s/he chose to rely on the above-specified types of information (or others) during the encounter.

In this paper, we will first identify the types of knowing that were diagnostically valuable in the encounters we studied and examine why. While many of these types of knowing are considered of low or dubious epistemic value in general diagnostic reasoning, we will argue that they are essential to good psychiatric diagnostic reasoning. We will further argue that determining what counts as diagnostic evidence in psychiatry is an issue that is both epistemic and ethical in nature.

10:00 Boorse's Theory of Disease: Do Values Matter?

Brent Kious

According to Christopher Boorse's widely-cited *biostatistical theory* (BST), a disease is a statistically abnormal reduction in one or more biological functions characteristic of an age-group of a sex of a species, where these functions ordinarily contribute to survival and reproduction. Boorse has repeatedly claimed that this analysis is value-neutral, but many of his critics have argued otherwise. Kingma, for instance, suggests that Boorse's appeal to reference classes is value-laden because there is no natural reason to prioritize age, sex and species relative to other reference classes (race, sexual orientation). Engelhardt, Ereshefsky, and others take a different approach, arguing that the BST invokes values because it appeals to the "goals" of natural selection, namely, survival and reproduction, but these are not distinctly *human* goals.

Although Boorse may have responses to these criticisms, in the paper I assume they are largely correct. Instead, I want to examine why this debate matters at all--that is, why does it matter if the BST, or biomedicine's concept of disease more generally, is value-neutral? I suggest that there are two basic respects in which value-neutrality might appear important. The first is that it may seem that the scientific legitimacy of a concept depends on value-neutrality. I argue, however, that this is not always the case, as a scientifically legitimate theory could make reference to values if these provided an efficient way of explaining observed phenomena. The second way values may affect the legitimacy of a theory is by making that theory morally illegitimate. Scientific theories often have practical significance, and this is clearly true for our concept of disease, which helps structure many different social policies and which is also associated with significant stigma. If a scientific theory is value-informed, if it has significant practical effects, and if the values it references are contentious, then the theory may seem to be morally illegitimate because it is illiberal and unfairly disadvantages persons whose goals embody different values.

I argue, however, that even if the BST is value-laden, this is not itself sufficient to show that the account is morally illegitimate. If we regard the BST concept of disease as a tool used in biomedicine and the social institutions associated with it, then whether the concept is morally permissible is really a question about whether it makes for the best available social policy given relevant scientific limitations. Our concept of disease has both negative and positive consequences for policy and how different persons are treated, and whether we should continue to use this concept depends primarily on whether the balance of benefits and harms is favorable, relative to alternative conceptual schemes. This is in many respects an empirical matter, and so from a philosophical standpoint an open question. Accordingly, even if the BST is value-informed, Boorse's opponents have yet to show that this renders the BST invalid; conversely, Boorse may be wrong to place so much stress on its being value-neutral.

10:30 Pragmatic Encroachment and Objectivity in Forensic Psychiatry

David Frank

Stone (1984) infamously argued that forensic psychiatrists face insuperable ethical problems due to the conflicting demands of the adversarial court system and their roles as medical practitioners. This became known as the "dual role," "dual agency," or "dual relationship" problem (Ward 2013; Robertson and Walter 2008), as it is widely acknowledged that the obligations of an expert witness in a court of law, to be truthful and aid in the administration of justice, can be incompatible with the obligations of a clinician, particularly beneficence or concern for the welfare of the individual patient. Appelbaum (1997) argued that the dual role problem in forensic psychiatry could be eliminated by appealing to the *function* of the psychiatric expert witness in the juridical context, which is *not* to provide medical care, but rather only to aid in the administration of justice. Thus Appelbaum's principles of ethics for forensic psychiatry focus primarily on truth-telling and respect for persons. Crucially, forensic psychiatrists are obliged to make clear to those they evaluate that they are *not* assuming the normal clinical role of a healer.

This paper argues that, even on the assumption that forensic psychiatrists follow Appelbaum's principles and abandon the role obligations of the clinician, an analogous problem of competing values reemerges in the context of the obligation of truth-telling. This is due to the philosophical problem of *pragmatic encroachment*, or the effects of practical stakes and values on knowledge and other epistemic states, also known as the problem of *inductive risk* in philosophy of science (Douglas 2008; Miller 2014). While pragmatic encroachment arguments take various forms, the general idea is that the values at stake in a practical context can affect the epistemic "burden of proof" for knowledge claims. I argue that this poses a challenge to forensic psychiatry to develop more detailed norms of objectivity that provide guidance on how to balance competing values in difficult cases (American Academy of Psychiatry and the Law 2005). I illustrate this problem with reference to a case study and suggest applying recent work from the philosophy of science on objectivity (Douglas 2004, 2008).

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11:10 Social Epistemology in High Functioning Autism

Bob Kruger

In recent years the concept of "epistemic injustice" has gained traction in philosophy and represents an overlap between epistemology and ethics (Fricker, 2007). In this paper I will explore the concept of social epistemology and, in particular, how knowledge of other persons as social actors arises in most individuals but fails to do so adequately in those with autism. This exploration then logically raises the question of whether psychotherapy can act as an antidote to this type of epistemic failure and whether epistemic injustice is a useful concept in the amelioration of some facets of autism.

Autism is a condition characterized primarily by deficits in social perception, social cognition, and social communication. These deficits can vary in a spectrum-like fashion from mild to severe. Individuals with autism can also vary with regard to their intellectual and linguistic capabilities. In the past (prior to DSM 5), those with average to superior intellectual and language skills but significant deficits in social capacities were identified as having Asperger's disorder (DSM IV, ICD-9) which was considered a variant of autism. Currently, individuals with this pattern of social and cognitive functioning are classified as having high-functioning autism the key features of which are often exceptional intellectual capacities but poor social awareness and communication skills.

A fundamental feature of those with high-functioning autism is that they either lack or possess a diminished theory of mind which would permit them to infer the mental states of others. Such theories of mind develop early in infancy and are a powerful feature of the way infants interact with caregivers. As a child's theory of mind emerges and evolves through perceptual and sensory experience with the physical and social worlds of other humans (largely through joint action and joint attention), it permits the child to infer and understand the belief and knowledge states of others. In this way, a child is constantly revising what s/he thinks and knows about other people, particularly the way other persons approach the world including (most importantly) the child him- or herself. In this way children develop what might be called *socioepistemic awareness*, i.e., awareness of what others know about one another. Thus, epistemological concepts are fundamental to how normal children interpret the world. The degree to which these concepts bear some veridical relationship to what happens in the world (i.e., by allowing the child to interpret and predict the actions of others) is the degree to which the child can make sense of how others behave and can form rational narratives about what the social world is like. In this sense, children use Bayesian reasoning to revise hypotheses as they grow older about what other actors think, intend, and do. Accordingly, a child's social narratives evolve as her/his abilities to grasp the underlying import and meaning of the actions of other agents evolves. In this way a typical child's hermeneutic capacities emerge and become more nuanced.

11:40 Co-Producing Meaning in Psychiatric Contexts and Form of Expression Bias

Elianna Fetterolf

In 1990, the NHS and the Community Care Act was launched in the UK, which commits mental health policy to the empowerment of service users. However, despite the currency of key words such as recovery and co-production, this commitment has achieved less than intended. In this paper, I focus on the failures of co-production in psychiatric contexts diagnosing its central problem as one of ‘shared words, unshared understandings’ impairing the effective delivery of mental health services. At the level of direct interaction between a speaker and a hearer, co-production aims at achieving shared understanding between the parties. But, aligning individual significances or meanings in a given testimonial exchange in a particular social context can be variously problematic. Drawing on Miranda’s Fricker’s (2007) work in *Epistemic Injustice: Power and the Ethics of Knowing*, I conceptualize one of the central ways these testimonial exchanges can go wrong at the level of ‘shared words, unshared understandings’: what I call *deflationary* ‘form of expression bias’ (FEB). Deflationary FEB occurs in a testimonial exchange when a speaker, using a particular form of expression, is not heard as fully rational (i.e., not credible) irrespective of the expressed content with respect to knowledge. The hearer does not hear what the speaker is saying as fully rational owing to the hearer’s associating the form of expression used with negative, or as lacking positive, epistemic qualities. Moreover, making the gap in understanding wider, the association between the form of expression, and its supposed negative epistemic qualities, can be perceived by the hearer as epistemically authoritative. Broadly, the mechanism of FEB is that the form or style of expression is used by the hearer *as a proxy* for credibility, thereby by-passing an assessment of the content or knowledge itself.

I explore two ways in which deflationary FEB operates: (a) *exclusionary* FEB occurs when the content conveyed by a subject is excluded from consideration as knowledge merely owing to the style or form in which it is expressed, and, (b) *distortive* FEB occurs when a subject’s knowledge gets variable uptake owing to it being translated into a ‘credible’ though non-commensurate form. What this discussion makes available is a way of understanding how a speaker, who can perfectly well understand what they are saying, and takes it to be representative, even intrinsically so, of their experience, cannot be heard as fully rational or credible. The hearer may literally understand what the speaker is saying but dismiss it owing to the form of expression it takes. Mapping FEB and its operations offers a way of thinking about a commonly concealed source of misunderstanding that can arise when parties to a communicative exchange express their views using different, sometimes incompatible, styles or forms of expression; something which I argue prevents or frustrates co-production between mental health service users and clinicians.

12:10 LUNCH

1:45 Accommodation or Cure: A Synthesis of Neurodiverse and Cure Theory Recommendations

Chandra Kavanaugh

As a result of vocal autism activists pushing against traditional views of autism, there is a bilateral debate that reflects a deeper philosophical divide between medical and social definitions of disability. Both sides seek to determine the manner in which autistics and their communities view autism, and thus influence the manner in which cures or treatments are sought, dispensed, and taken up. Through an investigation of this debate, this project will explore the practical benefits and ethical obligations of accommodating autistic differences. One side of this debate, which we will call the cure theory approach, seeks treatments that will eradiate or at least minimize autistic symptoms. The philosophical assertion that lies behind this objective is that autistic differences, particularly disruptive autistic differences, ought to be removed. The other side of the debate, which we will call the neurodiverse perspective, seeks to define autism as neurological difference, that is relationally determined, rather than a disorder or a syndrome. The neurodiversity movement recommends educating autistics and their communities regarding how to fully accommodate autistic differences. The underlying philosophical commitment of the neurodiverse perspective is that it is in the best interests of autistics and their communities to accommodate differences, rather than seek treatments that encourage conformity. I will argue that these two sides are not mutually exclusive. Through a synthesis of the neurodiverse and cure theory points of view I will enable the development of a method, which facilitates justice for autistics and their communities. This synthesis garners the maximum capabilities that the expression of autistic differences can offer, and maintains the freedom for all community members to actualize their capabilities.

I begin by giving a general account of the cure theory view of autism as it is illustrated by the policies and literature of the most powerful autism-focused charity, Autism Speaks, followed by a description of the treatment of autism that such a standpoint leads to. Given an overview of the practical applications of cure theory, I explore the philosophical tenets that underlie the perspective, namely, reliance on the medical model of disability, which treats disabilities as problems to be solved or minimized. The neurodiverse account of autism offers a significantly different picture of what it means to be autistic; as a result the neurodiverse perspective leads to vastly different recommendations for action. Neurodiversity relies on the social model of disability, an entirely different theoretical understanding of disability than the medical model. This view argues in favor of the social accommodation of autistic differences, while cure theory argues that species-typical function ought to be enforced through treatment. In this project I use a contractualist approach to bring together these two different views of autism, and their underlying models of disability, by reconciling the recommendations for action and the views of autism that are taken by neurodiverse and cure theories.

2:15 The Deficit View and Its Critics

Janette Dinishak

In this talk I examine what it is to understand human differences in terms of *deficits* and criticisms of this approach. My focus case is autism. Autism is a neuro-developmental condition that can manifest in diverse ways in different individuals with the condition but also over the lifetime of one individual. It is diagnosed via behavioral criteria: social-communicative difficulties (e.g., little or no eye contact, failure to initiate or respond to social interactions) and repetitive or stereotyped activities (e.g., spinning objects, echolalia, hand flapping). Although we have some clues about possible environmental triggers and autism's biological underpinnings, its causes are unknown. Perhaps the most well-known and influential instance of a deficit treatment of autism is the "theory of mind" account. On this view, autists have a specific cognitive deficit: a lack or delay in the development of the "theory of mind" module. This module is supposed to account for typical individuals' ability to attribute mental states (e.g., intentions, beliefs, desires) to oneself and to others, an ability thought to be integral to explaining and predicting behavior.

In the past few decades, across many fields of inquiry (e.g., psychiatry, psychology, sociology, education, disability studies, and anthropology), there has been a surge of interest in critiquing "the deficit view" of all manner of deviations from the norm, not just autism and other psychiatric conditions. Some critics go so far as to suggest that a deficit approach to understanding human differences diminishes a person's life chances and even their humanity. As such, on this view, challenging deficit thinking is seen as a moral imperative. But what exactly is meant by "deficit view", "deficit-based approach," "deficit model", "deficit thinking," "deficit explanation," and related terms when they figure in critiques of theories of human differences? In these critiques, the meaning of "deficit," "deficit approach" and like terms is often taken for granted and there is little systematic discussion of what constitutes a deficit approach. A survey of deficit critiques in the history of philosophy and science and in recent times suggests that "deficit approach" and like terms are used in relevantly different ways. (Here I use them interchangeably.) Further, as I will show, there are a number of ambiguities in critics' articulations of what is problematic about deficit approaches. Is the main claim in these critiques that deficit approaches are *never* appropriate or that particular applications of the approach, for example to autism and perhaps more widely, are inappropriate? That is, is the very idea of a deficit explanation of autism and perhaps more widely objectionable, and, if so, why? Do critics argue that deficit approaches are indeed harmful or will definitely prove harmful in the future? Or is the claim more tentative, for example, that the dangers of deficit views are significant enough to warrant our proceeding extremely carefully, in the case of autism and perhaps more widely?

My primary aims are to identify and articulate some of the conceptual unclarities at the heart of critiques of deficit approaches and to argue that this much-needed conceptual clarification can help psychiatrists and philosophers appreciate and address the important concerns raised by deficit critiques. One upshot of the talk is that the critiques teach us that deficit views may be socially harmful, but they also raise the question of whether, at least in some instances, deficit explanations may impede progress in our understanding of the phenomena themselves. Thus articulating and assessing deficit approaches is of practical and philosophical importance.

2:45 Considering the Social Utility of an Early Screening Program for Psychopathy

Lana De Gasperis and Dominik Alex Nowak

Is there a way to prevent potential harm from a psychopath when no harm has actually been committed? There is a rich literature on psychopathy. Philosophers and psychologists, neuroscientists and linguists have provided many novel insights into this troubling, yet intriguing personality disorder. The recent literature on psychopathy has, among other things, aimed at more diagnostic precision. It has attempted to distinguish between psychopathy and Anti-Social Personality Disorder; it has analysed whether and how a psychopath's brain is structured differently; and it has shown the linguistic differences between violent psychopaths and violent nonpsychopaths.

There is, nevertheless, a gap in the literature with respect to screening psychopaths on a *preventative* basis. The importance of screening is striking: Although psychopaths make up approximately one percent of the population, they are responsible for at least half of all violent crime. The damage caused by psychopaths is, accordingly, far reaching. Most of the time, forensic psychologists diagnose psychopathy (usually by means of the Robert D. Hare's PCL-R Psychopathy Checklist) *after* a crime or a series of crimes have been committed. In this paper, we argue that a screening approach would be indicated when psychopathic tendencies arise in school age children (*e.g.* callousness, lack of remorse, manipulation, violence, parasitic behaviour, shallow affect, and so on). The main conclusion we will draw is that early screening will help prevent some of the violent crimes committed by psychopaths. Under legal principles recognized by democratic societies, no one can be punished for crimes they have not yet committed. Nonetheless, in light of the fact that most psychopaths are not detected until incarceration, we argue that mental health screening is desirable to prevent the violent consequences of this disorder.

Screening would have consequences for psychiatric, legal, psychological, and societal measures and practices. While its main societal utility would be to prevent violent criminal behaviour by psychopaths, it would also serve to initiate any possible proactive therapy. There will be a role, after all, for preventative and rehabilitative psychiatry to take in psychopathy. Finally, understanding its invasive nature, we examine the moral aspects of childhood screening of psychopathy from the perspective of 'Libertarian Paternalism.' From this point of view, social and legal institutions could influence screening, but without compulsion. A libertarian paternalistic approach to screening will help influence participation, but will not take away the freedom of those who choose to reject the screening process.

3:15 Forced Treatment of the Severely Mentally Ill: A Feminist Bioethical Perspective

Norah Martin

In the wake of recent mass shootings in the U.S., the issue of how to deal with the severely mentally ill has taken on a new salience. Relaxing laws that protect people from treatment against their will is one solution proposed (for example, E. Fuller Torrey "Treat the 1 Percent" *National Review* Jan. 28, 2013, pp. 26-28]). From a feminist bioethical perspective, the issue of forced treatment is quite perplexing. On the one hand, some who refuse treatment end up living on the streets where they are victims of sexual violence and live in deplorable conditions. On the other hand, making involuntary treatment easier presents troubling possibilities. There is a long and sordid history of psychiatric “treatment” being used to enforce social norms, including gender norms. How do we reconcile respect for a person’s autonomy and personal integrity with care for the person’s well being? From what standpoint do we determine what is in a person’s best interest?

Psychiatrist and activist E. Fuller Torrey argues that because people with severe mental illness suffer from a brain disorder that causes them to deny that they are ill and thus refuse treatment, a phenomenon that previously was known as ‘lack of insight’, but which he, following Amador (1998), calls *anosognosia*, forcing mentally ill people into treatment is not only justified but morally required.

I argue that forcing people into treatment bypasses the need for respectful communication and for maintaining relationships, which are correlated with long-term treatment compliance and positive outcomes, as well as being more consistent with a feminist bioethical approach.

In her book *Refusing Care: Forced Treatment and The Rights of the Mentally Ill*, Ellyn Saks, Orrin B. Evans Professor of Law, Psychology, Psychiatry, and the Behavior Sciences, who is also a person living with a serious mental illness, outlines two perspectives on the issue of forced treatment: that of attorneys who advocate for the mentally ill, and that of psychiatrists. I will discuss these and also add a third important perspective: that of the family members of the mentally ill. Each of these perspectives purports to be the perspective that best takes into account the interests of the mentally ill. Saks makes a proposal to bring the two perspectives together that offers a significant contribution to resolving the perplexity faced by the feminist bioethicist with respect to the public policy issue. Because Saks herself has been diagnosed with schizophrenia, has been treated against her will and continues to be treated voluntarily as an outpatient today, her view should be taken as privileged. She is very much concerned that the mentally ill be treated with respect and that with respect to their civil rights, they should not be treated differently than anyone else. She also views it as important that medical professionals convince their clients to accept treatment rather than forcing them. Saks’ view dovetails nicely with the strategies developed by Xavier Amador. I argue, following Saks, that forcing people into treatment bypasses the need for respectful communication and for maintaining relationships, which are correlated with long term treatment compliance and positive outcomes, and is also more consistent with a feminist bioethical approach. While some people argue that we are leaving the mentally ill to “die with their rights on” (a description that originates with Treffert 1973) if we do not force them into treatment, I argue that if mental health professionals and families placed greater emphasis on respectful communication, for example following the LEAP model developed by Xavier Amador (2008, 2012), long term outcomes would improve and important values would be upheld. Those advocating for expanding forced treatment are taking a strong “ends justifies the means” approach that ultimately subverts the ends they claim to value in addition to sacrificing other important values. I note that while Torrey and Amador both hold that those who deny that they are mentally ill suffer from anosognosia, they focus on very different things as a result, at least with respect to Torrey’s statements in the popular press.

3:45 Is It Ethical to Change Memories to Treat Post Traumatic Stress Disorders

Miguel Vilaro

In a recent article that appeared in the general press entitled “Changing Memories to Treat PTSD” published in The Atlantic[i] the author ask if it is ethical to change memories caused by traumatic stress. This echoes prior concerns by the anti-psychiatry movement regarding the use of medication to change the mind. In addition, she makes references made by experts in the field regarding potential philosophical [anthropology] challenges with ontological and moral implications. These could succinctly be summarized by asking the following question: Does the practice of taking a pill for the purpose of "altering memories" may be considered "a fundamental violation of what makes [us] human?" This criticism can be extended to psychotherapeutic intervention consisting of "talk therapy" as well as the new emerging approaches that involve the monitoring and change in psychophysiology.

The occasion of her article was the publishing of a research review article on the topic of reconsolidation of memory that appeared in Biological Psychiatry[ii] earlier this year. The article reviews how memory is fixed but paradoxically also changed long after it was initially stored. The need of the article precedes an accumulation of new basic sciences research in memory reconsolidation in humans. These studies are currently leading basic science researchers-who had devoted their energy in studying animal models- as well as clinical researchers-who are now studying the impact on humans- to suggest translational studies with the purpose of implementing clinical studies in populations suffering from PTSD as well as Substance Abuse Disorders in the near future.

In my opinion, at the core of the philosophical debate is the dualistic way we conceptualize "memory." I believe that by practicing psychiatry in an integrated way, actions will demonstrate that memory reconsolidation interventions are natural, appropriate and necessary but also healthy. Using the concept of memory as a case example, I will attempt to trace its implicit dualist understanding in modernist science as well as in the popular mind. The literature vacillates between metaphors of substance and process in the use of the word "memory." The ethical implications follow this conceptual lack of clarity.

For, example, an ingestion of a pill could be seen as a violation of human rights or a step in restoring health. The appraisal of this act depends, in part, on our mindset. But, more importantly, the act of a mindfully clinical intervention provides the determining step in solving this philosophical quandary. New integrated practices in psychiatry and other allied professions provide the right setting for this activity. In specific, clinical practices that incorporate both neurobiological and interpersonal perspective broach the philosophical gap. Among these we find Biofeedback, Neurofeedback, Sensorimotor Psychotherapy, Sensory Experiencing, EMDR and Brainspotting to name a few. In these, neurobiological "top down" and "bottom up" approaches to pathology along within an interpersonal therapeutic relationship close the loop within a broader framework called dual attunement. An ethical approach within this dual attunement requires an ontological restitution, that is, reforming the self as it is originally meant to be. Therapeutic interventions imply reorganization of traumatic memories- those memories sequestered and distorted by pathology- and resetting them autonomously by the patient's psychophysiology.

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[i] Changing Memories to Treat PTSD by Cari Romm (August 28,2014).

[ii] Reconsolidation of Human Memory: Brain Mechanisms and Clinical Relevance by Lars Schwabe, Karin Nader, and Jens C. Pruessner. Biological Psychiatry (2014) 76: 274-280.

4:15 CLOSING REMARKS/DISCUSSION

4:30 ADJOURN