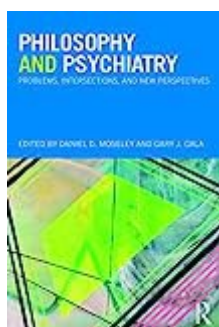


# METAPSYCHOLOGY ONLINE REVIEWS

## PHILOSOPHY AND PSYCHIATRY



**Full Title:** Philosophy and Psychiatry: Problems, Intersections and New Perspectives

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**Publisher:** Routledge, 2015

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**Review © Metapsychology Vol. 20, No. 36**

**Reviewer:** Anya Daly

*Philosophy, psychiatry and avoiding 'real mischief'*

“What is Dr. Monro? A mad-doctor; and pray what great matter is that? What can mad-doctors do? Prescribe purging, physic, letting of blood, a vomit, cold bath, and a regular diet? How many incurables are there?... physicians .... are often poor helps; and if they mistake the distemper, which is not seldom the case, they do real mischief.”

Alexander Crudden, *The Adventures of Alexander the Corrector*,

London 1754 [Quoted by Andrew Scull at the beginning of his chapter “The mad-doctor and his craft”, in *The Insanity of Place/ The Place of Insanity*, London, New York: Routledge 2006]

What can philosophy offer psychiatry? What can psychiatry offer philosophy? Simply, there is nothing as harmful as a bad theory put into practice and conversely the constraints of practice and the recalcitrance of the realities of anomalous experiences offer instructive challenges to theory. We know well that the history of medicine and psychiatry have many examples of bad theory having been put into practice often with tragic consequences. Equally the extremes of armchair philosophy and far-fetched thought experiments, while keeping some philosophers busy chasing zombies or possible worlds in which minds can be uploaded into a computer hard-drives, leave philosophy open to accusations of irrelevance and obfuscation.

Andrew Scull, and he is not the first, calls our attention to the political, economic and social dimensions of insanity, he writes: “For the lunatic, the madman, the psychotic, the schizophrenic, call them what you will, suffer a sort of social and moral death. Their wishes and will, their very status as moral actors, as agents capable of expressing valid preferences, and exercising autonomous choice are deeply suspect in light of their presumed pathology, as the often dark history of their treatment under confinement abundantly shows.” (Scull, *The Insanity of Place – The Place of Insanity*, 2006: 52). The stakes are thus immeasurably high and our efforts to avoid ‘real mischief’ demand critical appraisals of both philosophy and psychiatry, critical appraisals internal to each discipline and between these disciplines.

The collection of original essays in *Philosophy and Psychiatry: Problems, intersections, and new perspectives*, edited by Daniel D. Moseley and Gary J. Gala brings together diverse philosophers and psychiatrists in this effort of mutual critical engagement spanning the domains of phenomenology[αα], psychoanalysis, neuroscience, neuroethics, behavioral economics, evolutionary psychiatry, biopsychosocial models and virtue theory. In *Part 1, Psychiatric Diagnosis and Agency* and *Part 2, Ethical Dimensions of Psychiatric Treatment*, philosophers reply to the essays of psychiatrists and vice versa, addressing key issues in psychiatric practice and also the wider ethical implications of confinement and treatment. *Part 3, Philosophy Out of Psychiatry*, takes the discussion in a socio-cultural direction. The collection of essays brought together here goes to the heart of the many heated and often fraught debates within psychiatry about the autonomy of the psychiatric patient, the status of the mental disorder, the ethics of committing a person to psychiatric care, and of imposed medication and treatment. These issues all gear into the objectivism versus constructivism debate questioning whether psychiatric diagnosis is some absolute declaration of reliable authority on the part of psychiatric specialists on the state and status of an individual presenting with anomalous experience or whether this is an overt or covert mechanism of reinforcing social norms. Both the expertise of the psychiatrists and the benignity of the system within which they work and from which they draw authority, are called into question by constructivists. The question of moral responsibility of the patient also renders these investigations urgent as psychiatrists and those working in cognate disciplines are called on for expert testimony in courtrooms across the globe.

What is particularly heartening and interesting about this volume is that each of the contributors offers their analyses and critiques for the most part from outside of the domain of their interlocutor as they seek to address the theoretical and practical intersections galvanized by those with non-normal experiences of themselves, others and the world. They thus approach the task set by the editors with a freshness and openness increasingly less often encountered in academia wherein ‘expertise’ is not only reified but has also become yet another fetish of exchange in a so-called knowledge economy reliant on ‘market forces’. As the editors explicitly state, their aim is to invigorate the conversations across the disciplines of philosophy and psychiatry so as to make a positive contribution to the advancement of research, care and service. This volume in no way represents a comprehensive nor final statement on the issues under investigation and this is in fact a key feature of its *modus operandi* – final statements are impossible and if claimed become immediately suspect. The domain perhaps more than any other academic domain is characterized by inherent contingencies, evolution and fruitful intersections. Psychiatrists who ignore philosophy as much as philosophers of mind who ignore psychiatry do so to the detriment of their discipline and to their duty of care to patients, to students and to the wider society.

In the Introduction, the editors define the differentiation between the disciplines of psychiatry and philosophy in terms of their methodologies and subject matters. They propose psychiatry “include[s] the statistical and scientific tools of psychology, medicine, epidemiology, neuroscience and genetics. [Whereas] the methods of philosophy include the tools of conceptual, linguistic and logical analysis and the theories and interpretive techniques that have developed in the various traditions of philosophy” (p.2). This differentiation is in my view my first point of critique. Firstly, the neat distinctions they seek to draw here do not in fact hold up to scrutiny. These days there is much cross-fertilization between domains and furthermore this

differentiation seems at odds with both the very project they are engaged in with this book and also with some of the claims of contributors. Secondly, crucial elements are missing in setting out the methods and subject matters. In the description of psychiatry the significant contributions of phenomenology have been overlooked and correlatively the research in perception, embodiment, empathy and intentionality in philosophy. These last are key conceptions in the phenomenological tradition of Husserl, Stein, Scheler, Jaspers, Schneider and Merleau-Ponty, all of whom engaged with either aspects of philosophy of mind and/ or neurology and psychopathology and none of whom appear in the index. There is also a conspicuous absence of any of the current philosophers and psychiatrists working in the domain of phenomenological psychiatry. Thomas Fuchs, Shaun Gallagher, Dan Zahavi, Josef Parnas, Lisa Bortolotti, Matthew Broome, Chris Frith, Matthew Ratcliffe, to name a few that immediately come to mind.

Nicholas Kontos, Assistant Professor of Psychiatry at Harvard Medical School launches the exchanges with his thought-provoking article “Can what’s in your head be ‘all in your head’?: Possibilities and problems of psychological symptom amplification (PSA)”. He notes that the central problem of psychiatric diagnosis is that it suffers from inherent contingencies and uncertainties. This is due in large part to the inevitable reliance on the testimonies of both patient and family as well as due to the lack of reliable biomarkers apart from those that indicate the more definitive states of catatonia and other motor disturbances. Symptoms and signs comprise the core of any medical diagnosis and the signs are now bolstered with the information afforded via the various technologies of blood tests, scans and genetic screening etcetera. These latter provide the more ‘objective’ measures and the former, while crucial, are always subject to revision and doubt.

Kontos describes the especially fraught challenge the psychiatrist faces in establishing a diagnosis with any confidence. Despite the fact that our strongly-held assumption that symptoms, the interior experience, of the patient should figure prominently in diagnosis, much of what is reported defies the classifications offered by manuals such as the DSM. Kontos presents us with some concerning statistics that reveal that the on-the-ground practice of psychiatrists is less symptom dependent than supposed and, furthermore, that the process of psychiatric diagnosis suffers from a circularity which renders unexplained symptoms impossibilities (p.8). Kontos’ essay invites us to consider the controversial question as to whether the idea of a medically unexplainable symptom can be usefully transposed into the domain of psychiatry. He writes: “this means asking if there exists a psychological analogue of somatizing” (p.8) and this would be “psychological symptom amplification”. Importantly, Kontos acknowledges that not only does this issue concern the reliability of diagnosis and the patient-doctor relationship, but is also underpinned by more metaphysical concerns of identity and dualism.

Kontos’ begins his analyses by explaining the medical concept of Somatic Symptom Amplification and highlights the contested nature of the terms used to describe this. The terms ‘medically’, ‘unexplained’ and ‘symptoms’ are all open to interpretation and this again brings to the fore the question of underpinning metaphysical assumptions. He then goes on to discuss how the notion of somatization has evolved drawing on key developments in psychiatric history up until its official recognition with DSM-III and beyond to the now predominant integrative model. Kontos offers an insightful discussion of the psycho-social, politico-cultural dimensions in the endeavor of gaining ‘sick-role status’, drawing out the covert and complex motivations on both sides of the equation, whether as diagnosing psychiatrist or as diagnosed patient. Kontos empathically asks – “who among us could not at one time or another use a little absolution, release and nurturing?” (p.12).

Returning to the issue of underlying metaphysical assumptions, Kontos proposes that “there are few card-carrying dualists on the record in psychiatry” (p.15). Nonetheless, despite this claim, dualist thinking still continues to inform much of the conceptual analyses of psychiatry in general which tends to draw on the conceptual frameworks of the mainstream analytic philosophical tradition rather than with the more complementary tradition of phenomenology. Puzzling? Paradoxical? Or just politics?

Kontos’ concluding remarks bring us back to the conundrum that faces psychiatrists – do they assert an absolute authority to make the call on whether the symptoms of the patient are veridical or not, or do they give the ‘benefit of the doubt’ to all the patients’ claims? Ultimately, neither approach is satisfactory.

Philosopher, Justin Garson, provides the response to the essay by Kontos and declares he has nothing in the way of criticism but that he would offer a complementary essay that provides more of the historical context for the debates addressed. Garson is particularly concerned with the issues around what he calls “the hiddenness of psychological symptom amplification”, which he rightly argues has deep historical and institutional origins (p.29). Garson notes that the ascendancy of the view that symptoms were indications of inner dysfunction as opposed to the preceding view which regarded them as means for coping with untenable external situations, has effectively elided PSA from psychiatric consideration. Trainee psychiatrists are not trained to ask whether the patient might be faking it or exaggerating their symptoms or erroneously identifying non-existent symptoms. Their role is in the alleviation of suffering and confusion, and if they have medical means at their disposal to make the patient feel better, they will understandably pursue this path. The medicalization of everyday problems is yet another cause of the hiddenness of PSA according to Garson. Quoting Thomas Szasz, he writes that medicalization occurs when ‘problems of living’ transmogrify into ‘medical problems’ (p.30). While this has had positive benefits for the destigmatization of mental illness, it has also led to an explosion of people seeking ‘sick role status’ for the benefits this affords. Garson then goes on to track the historical and institutional factors that have contributed to the hiddenness of PSA in American psychiatry.

The second pairing of thinkers, Marc Lange – Theda Perdue Distinguished Professor of Philosophy at the University of North Carolina at Chapel Hill and Abraham M. Nussbaum – Assistant Professor in Psychiatry at the University of Colorado Medical School, tackle the specificities of mental illnesses, ‘How are mental illnesses different?’ – (1) from one another, (2) as opposed to mental health, (3) in distinction from unhealthy mental states that are not in themselves illnesses, and also (4) in differentiation from somatic illnesses.

As Lange notes with regard to the first difference, mental illness is regarded as a medical natural kind when what is discovered persists across all instances independent of context and discoverer, thus avoiding the critiques of constructivists (p.37). Such facts can then be used to determine whether one patient shares the same illness as another, and by extension if this is so, then the treatment of one will be just as effective for the other. Lange proposes that the second distinction between mental health and mental illness could be teased out according to whether, as he puts it, “unwellness [is understood as] a departure from statistically normal functioning, or [a] reduction of evolutionary fitness, or [an] interference with human flourishing, or [a] deviation from prevailing cultural ideals” (p. 37). He chooses not to pursue these lines of investigation because he wishes to focus specifically on etiologies as set out with the first differentiation. With regard to the third differentiation, between mental diseases and pathological mental conditions that are not in themselves diseases, Lange suggests this will only become clear once the first issue is addressed. Finally, the fourth differentiation gears into all the previous issues. Lange writes: “I

will examine whether mental and somatic illnesses differ in the grounds of their individuation, their status as medical natural kinds, and their distinction from pathological conditions that are not diseases” (p.37).

Throughout his analyses, Lange makes pertinent comparisons between disease as understood in general medical contexts and those in psychiatric contexts so as to more effectively draw out the specificities of psychopathology and these comparisons hinge on whether the disease in question can be considered a natural kind. Importantly, Lange stresses that manuals such as the DSM serve to provide diagnostic criteria and do not provide definitions as such. In this way the heterogeneity of mental disease can be accommodated without reductivism. In his concluding remarks, Lange suggests that the very notion of disease will play a lesser role in both medical and psychiatric diagnosis as molecular medicine gains increased currency.

Nussbaum, as a practicing physician, brings Lange’s philosophical interrogations into the clinic to test where they meet or fall short of the practical requirements of diagnosis and treatment. Can the specificities of general medical disease be translated effectively into the psychiatric domain? Nussbaum affirms Lange’s claim that it is in virtue of being incapacitating that general medical diseases overlap with those of mental diseases, but he challenges Lange on the claim that not all incapacities are diseases (p.54). Nussbaum takes Lange to task on his discussion about mental disease and agency because this then gives mental disease the same status as mere somatic disease and in so doing fails to adequately acknowledge the pervasive stigma that attaches to mental disease. Nussbaum rightly highlights the stigmatization that almost inevitably accompanies the diagnosis of mental disease in contrast with the diagnosis of medical disease which may alleviate the distress of the patient, giving them some surety. Drawing on the work of Lisa Bortolotti, Nussbaum situates mental disease understood as irrationality in the social wherein norms of rationality have erroneously tended to dictate the terms of debate. Nussbaum, in agreement with Bortolotti, suggests that irrationality is “neither a necessary or sufficient definition” (p.55) of what it means to have a mental disease; much that is irrational does not qualify as disease. Rather they suggest neuroscience may be better equipped to offer definitive answers to the questions of the underlying conditions of mental disease. Nussbaum returns at the end of his essay to the issue of agency and acknowledges that this notion requires a more nuanced understanding in that agency is not an all-or-nothing capacity.

The third exchange between Assistant Professor of Psychiatry, Warren Kinghorn and Professor of Philosophy, Christian Perring returns us to the vexed domain of diagnosis and the justifications of the highly controversial DSM-5 as a diagnostic tool. Kinghorn recounts the restrained reception of the book by clinicians who nonetheless have noted that “the DSM is too categorical in its diagnoses (as opposed to dimensional and narrative), too formal and cookbookish, too quick to pathologize, too fixed on static and stigmatizing labels, too focused on experience and behavior rather than quantifiable biomarkers where these exist, and too broad-brush in its categories – to name only a few complaints” (p.60). At the far extreme of the criticism is Gary Greenberg’s – *The book of woe: the DSM and the unmaking of psychiatry*, New York: Blue Rider Press (2013) – which chronicles the evolution and devolution of psychiatry’s principle reference and diagnostic tool. This is an informative but ultimately damning account of the latest version – the DSM-5 – and in addition to all the criticisms listed above, Greenberg exposes what he regards as the dubious ethics underpinning this particular iteration which effectively underwrites the commodification of suffering. Kinghorn’s essay thus serves as a corrective to Greenberg’s extreme account. Notwithstanding the legitimacy of some of the criticisms, Kinghorn asserts that the DSM is still an “important clinical and moral document” (p.61) despite the fact that it cannot claim objective and timeless status. As he writes: “It is not apolitical or timeless. It is not value-free or culturally neutral. It is not a document that ‘cuts nature at the joints’ in an objective

apolitical way, and therefore stands as a pinnacle of psychiatric progress. It is none of these things – which is to say that many, if not most, of the most common critiques of the DSM, are valid” (p.61).

Kinghorn aligns his inquiries with those of the philosopher Alisdair MacIntyre, who rejects both the grand ethical accounts of the 19<sup>th</sup> century and the deconstructivist genealogies of Nietzsche and Foucault in seeking a situated, progressive ethical theory. Kinghorn proposes this approach honors the strengths of the DSM while not ignoring its deficiencies. Kinghorn begins by tracking the major evolutions of the DSM and its more infamous ‘outings’ and omissions. He highlights the fact the one of the outstanding virtues of the DSM has been in the facilitation of communication between clinicians and patients, between different clinicians, between clinicians and the various health care systems, between clinicians and the pharmaceutical industry. This standardization of diagnostic language has informed the delivery of care, education and training, and research. And to be clear, this standardization has been the source of much controversy also. Politics at the levels of institutions and individuals have all come under scrutiny, thus muddying the waters of clear and dispassionate debate. Kinghorn questions why it is that these issues and documents arouse such outrage and indignation. He proposes that they go to the heart of very deep ethical issues and that thus the DSM must be analysed as much as a moral document, situated in time and place, as a document to facilitate diagnosis and interchange.

Perring while acknowledging the appeal and plausibility of Kinghorn’s defence of the DSM-5, proposes that the serious failings of DSM-5 have nonetheless not been exonerated. Perring challenges Kinghorn’s account on a number of fronts. Just as the Bible is known to be one of the most bastardized documents in history, so too the ‘the bible of psychiatry’, the DSM, is a highly political document. Nonetheless, those who refer to it do not generally accept it letter and verse; it is always open to interpretation. While acknowledging the DSM facilitates teaching, research and treatment, Perring is understandably suspicious of those who seek to downplay or co-opt the socio-political dimensions of psychiatry. As I mentioned in the beginning of this review – the stakes are immeasurably high and ‘avoiding real mischief’ should always be at the forefront of consideration in addressing the sufferings of those who seek and need psychiatric care. Perring offers a through-going analysis of the terms and claims which Kinghorn aims to defend, revealing ambiguities and dismantling arguments.

Underpinning Perring’s criticisms is his rejection of Kinghorn’s adoption of MacIntyre’s tradition approach; that is, the understanding of the DSM as a contingent tradition subject to historical and political forces without any absolutist claims to objectivity. While Kinghorn upholds these are reasons to defend the DSM, Perring takes the opposite view that they are cause for alarm and we must apply stringent standards of critical appraisals to each and every classification. Perring closes his essay on a conciliatory note, but again asserts the need for criticism and skepticism to be brought to the fore in our use of the DSM. He writes: “We can admire and respect the sincerity and good will of so many who work in psychiatric and mental health professions who use the DSM and do the research that supports research around it, and we may even hold a grudging respect for the tenacity of the DSM itself. However, we should maintain a critical and skeptical stance towards it, given its historical context” (p.87).

The above three pairings of essays are the opening exchanges in this collection which subsequently branches out into debates regarding ethics, free-will and responsibility, the justification of confinement and coercion in psychiatric treatment, the notions of self, autonomy and agency, and how all of these debates come to be represented in the media and film. One of the many virtues of this collection is the diversity of voices and the challenge to dominant assumptions across the domains of psychiatry and the philosophy of psychiatry.

The problem of dualism underpins a number of the issues in this volume and so it is surprising and disappointing that the contributors have not availed themselves of the rich and incisive critiques of dualism and mind/ body monism (aka physicalism or identity theory) on the part of phenomenologists so as to inform their analyses. Notably Merleau-Ponty is the stand-out phenomenologist who tackled this problem and established the first viable non-dualist ontology in Western philosophy. So too, for those who bemoan the limitations of the DSM, perhaps they could usefully investigate and employ the ‘phenomenological interview’ and ‘Shaun Gallagher’s ‘Pattern theory of self’ [BB] as alternative methods of anti-classification.

This collection of essays would make a valuable contribution to courses in philosophy of mind and psychiatry. The writing across all the contributions is generally clear and accessible to the non-specialist. These cross-disciplinary conversations will undoubtedly contribute positively to improved research, care, service and also help to guard against the dangers of ‘real mischief’.

Roy Porter reinforces the earlier call for caution from Crudden, Scull and Perring – he writes:

“All societies judge some people mad: any strict clinical justification aside, it is part of the business of marking out the different, deviant and perhaps dangerous.... Stigmatizing – the creation of spoiled identity – involves projecting onto an individual or group judgements as to what is inferior, repugnant or disgraceful. It may thus translate disgust into the disgusting and fears into the fearful, first by singling out difference, next by calling it inferiority, and finally by blaming ‘victims’ for their otherness.... The construction of such ‘them-and-us’ oppositions reinforces our fragile sense of self-identity and self-worth through the pathologization of pariahs.” Roy Porter, *Madness: A Brief History*, 2002: 62 & 63

Notes.

αα According to G. Berrios, “Phenomenology, psychopathology and Jaspers: a conceptual history”, *History of Psychiatry* 1991, 3: 303 – the term phenomenology has four possible meanings:

1. Phenomenology as referring to ‘signs and symptoms’. It is this interpretation to which contributors in this volume refer or just more generally the analytic philosophical use of this term. This usage seems to reduce ‘phenomenology’ to merely a synonym for ‘experience’ without the historical or ontological significances attached to the term found in the tradition, past and present, of Phenomenology.
2. The second – is merely a catalogue of the history of usages of the term.
3. The third concerns Jasper’s use of the term to refer to a description of mental states from an empathic and conceptually neutral standpoint.
4. Phenomenology according to the father of phenomenology Edmund Husserl and those who took up this tradition of philosophical analysis.