Philosophy and Psychiatry

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Preface

Philosophy and psychiatry not only have a common history but also share several concepts such as consciousness, self, identity, psyche and, of great significance, mind or mental. Plato was concerned with the harmony of the human soul. Aristotle's ethics developed an account of *eudaimonia*, or the good life. How should one live? This is one of the oldest questions of philosophy – and, similarly, the whole point of psychiatric treatment is to help people live their lives to the best of their ability. But despite their common roots, psychiatry and philosophy have become individual disciplines, philosophy being a human science (*Geisteswissenschaft*) and psychiatry being a medical discipline, identifying more and more with the principles of the natural sciences. This anthology is an attempt to bring back together what came apart. We are convinced that both psychiatry and philosophy can benefit from one another; that a fruitful interaction between the two disciplines will help to solve some common problems.

We asked several distinguished scholars, psychiatrists and philosophers to write on their preferred topic in order to give a comprehensive picture of the multiplicity of shared themes. During the preparation of this collection we were happy to notice a huge enthusiasm regarding these themes. It seems that the interest in the subject is much more pervasive and deeper than we expected. Maybe the time is ripe for launching a new philosophy of psychiatry, as recently suggested in the first issue of a book series on international perspectives in philosophy and psychiatry (Bill Fulford et al., *Nature and narrative. An introduction to the new philosophy of psychiatry*, Oxford U.P. 2003). Although we are aware of the problematic nature and inconveniences of interdisciplinary work and multi-author books, we believe that the collected essays are accessible both from a philosophical and a psychiatric perspective, thus demonstrating how philosophy and psychiatry may benefit from each other.

When conceptionalizing this book, the question arose whether it should be written in our native tongue or if the "lingua franca" of present times should be used. After intense discussions, we decided to publish this anthology in the English language. This made the task for several of our contributors, many of them non native-speakers, rather difficult (including ourselves), but will hopefully propagate a wide reception, enable a cross-national discussion and contribute to the international discourse about the conditions of the possibility of a philosophy of psychiatry.

We would like to thank all co-authors for their highly interesting and in many ways pioneering contributions.

Also, we are very thankful to Dr. Gertrud Grünkorn of our publisher de Gruyter, Berlin, for her encouraging support right from the beginning of

the planning and throughout the publication process of this anthology. Last but not least, we would like to express our gratitude to Kerrin Jacobs and Nicola van Dornick for their reliable and indispensable help with editorial and linguistical issues.

Mannheim, March 2004

Johannes Thome
Thomas Schramme

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Introduction: The Many Potentials for Philosophy of Psychiatry

Thomas Schramme and Johannes Thome

Psychiatry is a philosophical discipline. This might come as a surprising and even provocative claim. But it is obvious that in psychiatry many theoretical and practical issues have a philosophical connotation. What probably comes to mind first are ethical issues in the treatment of psychiatric patients. Confidentiality, informed consent and the criteria of competence, coercive treatment, the insanity defence, psychopathy and some other problems must be dealt with in medical ethics and law. Although they may raise specific questions in psychiatry, it is widely accepted that efforts to deal with these problems may benefit from a philosophical point of view, since ethics is, of course, one of the main and traditional subjects of philosophy.

But there are several other, more theoretical topics relevant to psychiatry which could also take advantage of philosophical expertise, but where, surprisingly, collaborations are hardly to be found. Examples include the mind-body-problem, freedom of the will, the concepts of rationality, of causation, of classification, the debate on the dichotomy of science and humanities (or natural and social sciences), personal identity, consciousness, the problem of other minds. These are common themes in theoretical philosophy, more specific in metaphysics, epistemology, action theory, philosophy of science, and philosophy of mind with the utmost relevance for psychiatry.

What about philosophy being a psychiatric discipline? Since not only could psychiatry gain by philosophical knowledge, but philosophical debates could be enriched by psychiatric expertise, too. Philosophy used to be regarded as a therapeutic discipline. Although this idea has declined in the past few centuries, especially in academic philosophy, it is still of some relevance. Many people today search for a meaning in their life, several still look for answers in philosophical books and some try to solve their problems by philosophical assistance. Admittedly, psychiatric illness is different from spiritual deficiency. But nevertheless, philosophy should be aware of its long history concerning the question of how we should live because there is a demand for "therapy" which overlaps with psychiatry.

Theoretical philosophy, too, can be enriched by considering psychiatric issues. For example, there is a common objection to certain theories in the philosophy of mind that have not been developed on the basis of empirical data, but mainly by means of thought experiments (Wilkes 1988). Psychiatry,

in contrast, deals with real, not "possible" people, and certain philosophical accounts can, thus, gain support or opposition by their cases. For example, consider the philosophical problem of the unity of consciousness. How is it possible that sense-data and attitudes are integrated into one perspective, in the point of view of a self? Usually, philosophers – and not only them – tend to think of a person as consisting of just one self. They like to believe that there is only "one self to a customer" (Dennett 1991, p. 422). But what about patients with split brains, patients suffering from paranoid-hallucinatoric schizophrenic psychoses or persons experiencing multiple personalities? These real-life cases can put into doubt some philosophical theories about the unity of the self.

Because they are of obvious interest for philosophers, the so-called dissociative identity disorder, cases of patients with split corpus callosum and the phenomenon of schizophrenic psychoses have already caught the attention of some philosophers (Flanagan 1996, Glover 1988, Metzinger 1993, Metzinger 2003, Nagel 1971, Wilkes 1988). It should be mentioned that there are some other examples of already existing interdisciplinary discussions but these are still few considering the potentials (Baron-Cohen 1995, Bolton and Hill 1996, Graham and Stephens 1994, Löw-Beer 1990, Northoff 1997, Emrich et al. 2002, Heginbotham 2000, Heinze and Priebe 1996, Heinze et al. 1996, Hundert 1989, Fulford 1989, Fulford et al. 2003, Phillips Griffiths 1994, Reznek 1987, 1991, Sadler et al. 1994, Sadler 2002, Schramme 2000, Spitzer et al. 1988, 1990, Stephens and Graham 2000, Straus et al. 1969, Theunissen 1991).

In summary, psychiatry is neither a philosophical discipline nor philosophy a psychiatric discipline. However, philosophy as a fundamental reflection of the *conditio humana* can make significant contributions to the elucidation of the theoretical background which drives psychiatric research and practice. Vice versa, psychiatry as a rational science of the human mind and brain may enrich the philosophical discourse about several issues by pragmatism, rationalism, empirism and relevance.

Philosophy of psychiatry: Recent and past

Although philosophy of psychiatry is an emerging discipline, it already has a history even if there is admittedly more interdisciplinary work done in the related field of philosophy of psychology. Up to now, a considerable number of anthologies, authored books and articles has already been published. Several networks of scholars have been installed, at least one academic journal dedicated to this subject has been founded (*Philosophy, Psychiatry & Psychology*), and several conferences have taken place and enhanced the international collaboration of scholars in this field. A special masters degree in the "philosophy and ethics of mental health" is now available at the University

of Warwick/England and the International Network for Philosophy and Psychiatry (INPP) has been launched. So it seems that philosophy of psychiatry today has at least a preliminary standing.

Arguably, the first modern classic of philosophy of psychiatry proper is Karl Jaspers's *General Psychopathology*, published in the first edition in 1913. In addition, Jaspers is one of its champions *in persona*, since he was trained both as psychiatrist and philosopher. Although in his work he was already concerned with almost all the main philosophical topics in psychiatry – whether or not psychiatry belongs to the natural sciences, the concept of mental illness, diagnosis and classification etc. – he is most of all remembered for his account of the subjective side of mental illness. A psychiatric patient not merely has a disease but is ill. Therefore, he or she develops a certain point of view which needs to be understood by the psychiatrist. Consequently, the task in psychiatry does not only consist in finding explanations of disorders but also in understanding patients as persons who take a subjective perspective.

Phenomenology is one of the traditional methods in philosophy dealing with the issue of understanding other minds and developing an account of subjectivity or the 'lived-world'. Jaspers is one main reference for phenomenological theories in psychiatry today. In addition, there is a recent interest in the work of Edmund Husserl, who was the founder of the phenomenological movement in Europe.

Although the common distinction between continental and analytical philosophy rightly became under attack in recent years, it is clear that Husserl and Jaspers stand for a certain tradition of philosophy. There is another tradition in philosophy of psychiatry which is connected to so-called analytical philosophy and is fuelled by an adherence to a scientific worldview. This philosophical account is potentially in conflict with the tradition of phenomenology. Gilbert Ryle may be named as one of its modern advocates. In his seminal book *The Concept of Mind*, published in 1949, Ryle tried to overcome Cartesian dualism – the dichotomy between *res extensa* and *res cogitans*, which was introduced by the French scholar René Descartes in 1641 and still is influential today – by analysing the language we use to refer to mental states and mental acts. Thereby, Ryle became one of the leading figures of 'ordinary language philosophy'. He maintained that the common distinction between mind and body rests on a certain linguistic error that could be labelled as 'category mistake'. He rejected Cartesianism as 'the dogma of the ghost in the machine' and developed his own theory of mind by defining mental terms in behavioural language, i.e. by reference to observable events.

Another strain of this philosophical tradition can be found in the proponents of Logical Positivism. In its early years, Rudolf Carnap, Friedrich Schlick, Otto Neurath, Alfred Ayer and their collaborators developed an account which focused on the reduction of all mental terms, thus psychology, to physics. They were highly critical of all metaphysical, i.e. non-verifiable

statements which they especially ascribed to Martin Heidegger. Although their highly ambitious research program failed and reductionism in the philosophy of mind is widely abandoned today, their scientific and naturalistic worldview still lives on. Some recent publications in philosophy of psychiatry are clearly influenced by this tradition.

Last but not least, one can find some references to the early Greek philosophical tradition, especially regarding ethical questions in psychiatry. This interest can be seen in relation to the recent developments in virtue ethics, which, of course, mainly goes back to Aristotle's *Nichomachean Ethics*. But other theoretical issues, such as teleology, are also to be found in this context. Furthermore, it has been shown that Plato anticipated several modern concepts of the human psyche and developed a philosophy with considerable psychotherapeutic aspects (Thome 1995).

Certainly, none of what has been said so far should suggest one or another preferred way of seeing things in philosophy of psychiatry. On the contrary, we would like to point out the variety of philosophical traditions which may underlie different viewpoints. In this anthology, we have tried to show the potential of different philosophical perspectives for psychiatry in its multiplicity.

Up to this point, we have focused on establishing that there is a real potential for fruitful collaboration between philosophy and psychiatry which could aid both disciplines. In the next two sections we would like to give some evidence supporting our claim by discussing in greater depth two philosophical problems of psychiatry: Firstly, the mind-body-problem, which is one of the oldest topics of philosophy and also the most basic conundrum in psychiatry. Secondly, the philosophical debate on the concept of mental illness.

Mind, brain, and mental disorder

Some years ago, on the occasion of the annual "Festival of Science" of the British Association for the Advancement of Science, *The Guardian* published several short articles to inform the public about recent developments in different academic disciplines. The author who wrote about schizophrenic psychoses reported: "Now that it is generally accepted that schizophrenia is a disease of the brain, the next question is: how does it come about? There is little evidence of active degenerative changes in the brain, and it seems more likely that what goes wrong reflects an abnormality in brain development occurring early in life, perhaps even in the womb." (Iverson 1997)

These sentences represent a common opinion about mental illness, especially schizophrenic psychoses. Although there are no clear, generally accepted and in every single case demonstrable correlative disorders of the brain, i.e. neurobiological and morphological correlatives, yet known, there is no ques-

tion that such mental illness is a brain disease. Usually this belief is fuelled by the efficacy of certain drugs which affect neurophysiological processes. Surely this fact should be seen as a hint at the general dependency of mental phenomena on brain processes. But does it imply that disorders which are identified on the level of the mental can be explained by respective disorders of neurophysiological processes? Can we abandon the reference to genuine mental processes? On the other hand, if we want to save the unity of body and mind, do we not need to search for mental illness in the brain?

There is an apparent dilemma in using the concept of mental illness. Thomas Szasz questioned its validity by rejecting the view that there can be a substance, called 'mind' or the 'mental', which can be affected by a disease in the way the body is. If we tried to counter this argument by explaining mental illness as manifesting itself in the brain, as the author of *The Guardian* article did, then we might question why we should still regard it as *mental* illness.

"Psychiatry is left with two seeming alternatives: either to say that personal, psychological and emotional disorders are really states of the body, objective features of brain-tissue, the organism-under-stress, the genes or what have you; or else to deny that such disorders are illnesses at all." (Sedgwick 1973, p. 127.) Peter Sedgwick describes a common opinion which leaves us only two options: either to somatize mental illness or else to question its medical status in principle. Many psychiatrists focus on biological accounts. When the concept of mental illness is based on physiological disorder like somatic illness then nothing counts against upholding medical terminology for psychiatric phenomena. But again, according to Szasz's opinion, this argument leads to a new problem. Why should one call diseases of the brain, hence somatically manifested illnesses, *mental* illnesses (Szasz 1987, p. 49)?

Thus adherents of the concept of mental illness may find themselves in an awkward dilemma: either they stress the bodily realization of mental illness and thereby perpetuate the analogy with somatic illness, and hence bio-medical terminology, but at the prize of losing the specific quality of mental illness, since it is reduced to bodily illness. Or they try to maintain the term of mental illness *sui generis*; but then it seems that they will have to postulate a mental realm which is distinct from the body. So this strategy, on the other hand, seems to lead to a mind-body dualism, which is no longer fashionable in philosophy. Thus the dilemma for adherents of the concept of mental illness seems to consist of the choice between the Scylla of reductionism and the Charybdis of dualism.

There are authors, especially psychiatrists, who are willing to dissolve the dilemma by consequently going the way of somatization (in the sense of physicalization) and thus actually abandoning the concept of mental illness. A prominent example is Robert Kendell: "[...] it follows that there is, strictly speaking, no such thing as disease of the mind or mental disorder and that

Griesinger was right – mental illnesses are diseases of the brain, or at least involve disordered brain function – because all mental events are accompanied by and dependent on events in the brain. (Thomas Szasz was also right; mental illness is a myth, though not for the reasons he believed.)" (Kendell 1993, p. 3.) Surprisingly, a downright grotesque alliance between so-called biological psychiatrists and sceptics like Szasz seems to be at hand: both are prepared to drop the concept of mental illness.

The task therefore consists of finding convincing arguments in favour of a concept of mental illness in its own right. From what we have said so far it might be already obvious that the dilemmatical structure can be put into doubt. There are possible positions between the extremes of the dilemma. For some (mainly philosophers who are interested in the modern debate on the mind-body problem), this will not come as a surprise, but many others (among them psychiatrists) are quite impressed by the critique of Cartesian dualism and believe the only alternative consists in biological accounts of mental disorder. Even the authors of the DSM-IV come up with the same argument: "Although this volume is titled the *Diagnostic and Statistical Manual of Mental Disorders*, the term *mental disorder* unfortunately implies a distinction between 'mental' disorders and 'physical' disorders that is a reductionistic [!] anachronism of mind/body dualism." (APA 1994, p. XXI)

There are many more alternatives to Cartesian dualism which do not seem to be widely known in present-day psychiatry (cf. Hannan 1994, Kim 1996). Anti-Dualism or Materialism about the mind does not necessarily commit to a reductionistic account. As mentioned above, theories about the relation of mind and body, which could result in the questioning of the concept of mental disorder, are *reductive*, i.e. they reduce the explanation of mental phenomena to statements about physical processes and therefore arrive at one extreme of the dilemma mentioned above.

This is not the place to discuss the relevant theories at length but it may suffice to allude to the fact that for a reductive account it would not be sufficient to demonstrate merely a *correlation* of some types of mental illness with particular neurophysiological states or processes. Rather, it would be necessary to prove an *identification* of mental with neurophysiological states which, in turn, would imply that every property of a mental phenomenon also has to be a property of a neurophysiological state, which was explicitly stated by the so-called type-identity theory (Smart 1959, Place 1956).

In the present-day philosophy of mind, reductionism is considerably less favoured than it used to be. Even if the problem of explaining consciousness and subjectivity in neurophysiological terms is disregarded – an awkward problem for every (even non-reductive) physicalist theory – the philosophical debate has demonstrated so far that there is a tall order for the reductionists. For example, Hilary Putnam's objection to the type-identity theory states that it is all too likely that the same type of mental state could be realized by

multiple different brain states (Putnam 1967). Furthermore, it is known that, in some cases, the opposite can be true, too: The same pathological brain processes may result in different mental states. In order to explain what a certain mental illness is, generalizations would be needed rather than the description of singular brain-states of particular individuals with mental problems. Since the same mental disturbance may be connected to different neurophysiological processes in various individuals, the possibility of a reduction of mental illnesses (at least as defined in today's international classification criteria) to certain brain diseases is quite unlikely.

Further to this, it seems that the particular property of a mental state being pathological could hardly be comprehended, understood and explained solely on a neurophysiological level. After all, to assert that a brain process is pathological depends on its tallying with *mental* problems. If it did not, we should have no reason to regard it as pathological. The identification and explanation of mental disorder *as disorder* needs to be done on a mental level.

So psychiatrists could learn from the philosophical debate that there is no need to give up talk about the mental realm in its own right, even if they have good reasons not to postulate a non-material "mind stuff". "The concept of mental disorder is just the concept that something has gone wrong with the way the organism's mind is designed to function. In suggesting that such disorders exist, there need be no deep metaphysical assumptions about the nature of the mind, any more than there need be deep metaphysical assumptions about the nature of kidneys in saying that kidney disorders exist. Whatever the mind is made of, as long as the mind encompasses an identifiable realm of phenomena (e.g., perception, thought, feeling), then disorders within that realm are mental disorders." (Wakefield 1994, p. 11)

Altogether, this implies that biological accounts of mental disease cannot suffice for a proper explanation of psychiatric phenomena. This, however, does not mean that one should disregard somatic accounts in psychiatry altogether, but points out only their limitations. Psychiatry, after all, should be neither 'mindless' nor 'brainless' (Sullivan 1990, p. 271).

The concept of mental illness

Thomas Szasz claimed that mental illness is a myth. He reached this conclusion by arguing that the concept of mental illness is not a proper one. His argument works on two premises. Premise one: Physical illness is defined as a "*structural or functional abnormality of cells, tissues, organs, or bodies*" (Szasz 1987, p. 12). This, for him, states a scientific norm. We merely need anatomical or physiological terms in order to define what somatic illness is. Premise two: We can say that mental illness is a brain disease, it is then recognized as a proper concept – because it relies on a scientific norm – but

then we lose a concept of *mental* illness in its own right. Alternatively, we need to argue for a different norm but by doing this we are necessarily bound to give up the scientific status of the concept: "The concept of illness, whether bodily or mental, implies *deviation from some clearly defined norm.* In the case of physical illness, the norm is the structural and functional integrity of the body. Thus, although the desirability of physical health as such is an ethical value, what health *is* can be stated in anatomical and physiological terms. What is the norm deviation for us to classify it as mental illness? This question cannot be easily answered, but whatever this norm might be, we can be certain of one thing: namely, that it is a norm that must be stated in terms of *psychosocial, ethical, and legal* concepts." (Szasz 1960, p. 21)

Since the norm consequently cannot be scientific, according to Szasz, the concept of mental illness merely feigns its proper medical status. We just hide our normative ideas of what we do not like, what we regard as bad or evil behind the mask of medical science. So the picture we get from Szasz can be summarized as follows: Mental illness is a myth because there is no proper scientific norm for its ascription. Unsurprisingly, the responses to his claim focus on his premises. Normativists argue against premise one, namely, that somatic illness is a scientific term. They assert that a definition both of the concept of somatic and mental illness involves a value-judgement. Naturalists, on the other hand, question Szasz's second premise. They claim that mental disease can be defined as a deviation from a natural norm.

We introduced the second premise as comprising two parts: Either you lose a concept of mental illness in its own right or, alternatively, you will end up with an unscientific term. Biological psychiatrists usually bite the bullet and talk in the tradition of Griesinger only about brain disorders. We already stated that it is very difficult to reduce the explanation of mental phenomena to the level of neurological events. But not all naturalists are reductionists. A naturalistic defender of the concept of mental illness accepts that there are scientific *psychological* norms and a deviation from those would be the criterion for the psychopathological. We will come back to this crucial issue but first we should say more about normativism.

At first sight, normativism is a very compelling theory. It seems perfectly clear that illness is *unpleasant, undesired* etc. In short, illness is harmful. Health, on the other hand, is a condition in which we feel well. Both concepts can only be defined by reference to our evaluations. This is the basic intuition of the normativists: illness always is a negatively evaluated condition (Engelhardt 1974, Nordenfelt 1987, Fulford 1989, Culver and Gert 1982).

Normativism can easily explain historical and cultural differences in the ascription of illness. For example, masturbation and homosexuality were regarded as mental illness for a long time because they were negatively valued. Today our values have changed in so far that only very few would see it as a medically relevant problem. Depending on how the involved value-judgement

is interpreted, that is, whether universal values are believed to be possible, the normativistic theory is also relativistic.

Many normativists additionally infer from the so-called disvaluation-thesis that illness is always a condition which should be cured. The very fact that illness is unpleasant leads to the desire to become healthy again: "Judging that some condition is a disease commits one to stamping it out. And judging that a condition is not a disease commits one to preventing its medical treatment." (Reznek 1987, p. 171) From this stance the practice of medicine is legitimized, because it eliminates – if successful – undesired conditions and restores health. This may be called the "intervention-thesis" of normativism. However, formulated in this way the first difficulties for the normativistic theory present themselves, since we do not usually think that medicine should deal with *all* undesirable conditions, but only the medically relevant ones, or there is the danger of medicalizing several disvalued phenomena, from poverty to lovesickness to rebellious behaviour. With respect to psychiatry, the provocative question would obviously be: Do psychiatrists really treat medically relevant phenomena or do they merely adjust "undesired" people to a social standard? Thus, the normativists need additional criteria in order to distinguish illnesses from other unpleasant conditions. In short, not every disvalued condition represents an illness even if illness might be necessarily disvalued.

The other side of this problem is to explain our intuition that there can be a pathological condition even if there is *no* negative evaluation. There are many examples of this: the crippled feet of women in traditional Asian societies corresponding to the ideal of beauty; the iodine-deficiency goitre in remote Alpine communities, worship of mentally ill people as "gurus" etc. Should we not regard these conditions as pathological even if they are not disvalued in the respective society or by the affected individual? Or should we say instead that the people in question are mistaken about the "correct" values?

We will now turn our attention to naturalism and come back to the question of the role of psychological norms and psychopathology. Naturalists start their account from the fact that humans are part of nature just as other organisms are (Boorse 1976, Scadding 1988, Guze 1992, Klein 1978, Spitzer and Endicott 1978, Flew 1973, Kendell 1975). Their basic intuition is that there are certain mental and bodily processes which may not work in the way they naturally do. If this is so, we speak of a pathological condition. That does not mean that disease is "unnatural" or that every unnatural condition is an illness. Naturalists merely assert that the *criteria* for the distinction of health and disease are to be found in nature and are not determined by social or individual values. It may be that we disvalue the condition but this is not the defining characteristic of a disease. Even if every disease were disvalued, it would not be up to us to determine the respective underlying norm. Thus, the concept of disease is value-neutral according to the naturalists.

From the naturalists' perspective, it can be explained why there should be universal disease judgements. Since human beings (just as other organisms of a respective species) are similar in their structure, they are affected in the same way by a disease if deviations from a natural norm occur. Nevertheless, there remains the possibility of variety regarding disease in the naturalistic interpretation. Although nature delivers the standard of medical normality it may have a different content in different environments. For example, supposing conditions of severe anxiety were universally regarded as illness then it may nevertheless express itself in different ways in different cultures. So there may be culturally impregnated diseases despite universal disease-judgements, e.g. the syndrome called "Koro" that occurs only in South- and East-Asia.

What naturalism does rule out though, is the possibility of an ascription of disease where there is no deviation from a natural norm. If there is such an ascription, like in the example of masturbation, then the disease-judgement is simply *wrong*, rather than "outdated" or "not adequate today" as some normativists need to assert. So the benefit of the naturalistic position is to reject interest-laden illness-judgements. If the criteria for the ascription of disease are determined by human nature then arguments about whether particular conditions are pathological – e.g. whether dissidents in totalitarian regimes are mentally ill – can be decided empirically.

Much more needs to be said about the plausibility of a naturalistic account concerning *mental* disease. After all, mental phenomena seem more detached from a naturalistic explanation than do bodily mechanisms and it might seem hopeless to try and find a natural *psychological* norm. But it is common to talk about mental functions, for example, in cognitive sciences or in the most interesting research program of evolutionary psychology. In evolutionary psychology mental functions are explained as universal features of the human mind which evolved through evolutionary processes, hence mental functions are explained naturalistically (Tooby and Cosmides 1992, Mithen 1996, Nesse and Williams 1994, Stevens and Price 1996, Gray Hardcastle 1999).

"Evolutionary psychology is the application of the adaptionist program to the study of the human brain/mind. Evolutionary psychologists assume that the brain/mind has many functions – i.e., that it has been designed by selection to solve many different kinds of problems, each of which is likely to require its own distinctive kind of solution – and, therefore, that the brain/mind comprises many domain-specific specialized mechanisms." (Symons 1992, p. 155f.) So this account interprets particular mental abilities as adaptations, i.e. as complex mechanisms which were designed by natural selection. Here is not the place to scrutinize this theory thoroughly, of course, but it shall suffice to point out that evolutionary psychology represents at least one interesting naturalistic model of mental functions and, hence, that a naturalistic account of mental disease needs to be taken seriously.

Usually, normativism and naturalism are regarded as mutually exclusive positions. But both accounts seem to be important in their own right, since they reflect two different perspectives on medical phenomena. One may even say that they are using different concepts, i.e. a theoretical and a practical. The different terms or notions "illness" and "disease" clearly contain these different perspectives: 'Disease' refers to the bodily or mental condition of a person irrespective of his or her situation otherwise. So naturalism is focused on the living organism and its functioning or dysfunctioning – the internal mechanisms an individual is or is not able to perform. Call this the *scientific* perspective. It disregards the meaning of a condition for the *person* – to use a common philosophical term. 'Illness', on the other hand, reflects the specific situation of and the evaluation by the person in question. So normativists concentrate on the evaluation of a specific condition, that is, what it means for a person to be suffering from an illness and why an illness should be eliminated. Call this the *evaluative* perspective.[1]

According to this interpretation of the philosophical debate on the concept of mental disorder, naturalists talk about disease as a form of pathological condition, normativists about illness as an impairment of well-being. There is nothing incompatible in these theories. We are interested in *explanation* as well as *evaluation*. There are many examples of these different but compatible perspectives. For instance, we usually talk in an objective way about artefacts but also from an evaluative perspective about works of art.

Now one might ask why we need the objective point of view at all. Is it not so that the evaluative perspective is the only significant one? It is true that naturalism cannot explain why we may have different and even conflicting evaluative views on deviations from a natural norm. The evaluative perspective is essential in order to reflect the individually different situations of the various people in question and thereby to generate a judgement as to what is the best way to deal with a psychiatric disorder. Normativists have expressed the idea that an ascription of illness necessarily implies the value-judgement that it is harmful affliction and the wish to eliminate it. If one takes the naturalistic perspective instead, nothing is said about the evaluation of a condition. So if the disvaluation of an illness forms the starting-point for the justification of a medical treatment then the naturalistic perspective needs to be *supplemented* by the evaluative perspective of the normativists. It does not need to be supplemented in order to determine what is pathological but it does in order to judge when an impairment of well-being is present and

1 Our conceptualization of these two perspectives is similar to the distinction between *nature* and *narrative*, which is introduced in Fulford et al. 2003. 'Nature' in this anthology stands for 'causes' and generally sciences, while 'narrative' stands for 'meanings' and generally humanities.

consequently needs treatment. For the patient concerned this is the relevant perspective on the phenomena of illness. So the answer to the question why we need an objective – or scientific – point of view is that we need it in order to distinguish the pathological from the normal without relying on subjective value-judgements. This is an important distinction which is necessary to bring to a halt the problem of medicalization. We already pointed out that normativists usually find themselves in trouble when explaining the distinction between illness proper and disvalued conditions in general.

In passing, we would like to make a minor point about the debate of naturalists and normativists: It is sometimes assumed that if a naturalistic account involves – contrary to its own assertions – reference to values of any kind, for example, because there is no value-free explication of the concept of function or because there is no value-free science, then the superiority of normativism over naturalism becomes evident. But this argument seems to miss a very crucial point concerning the kind of values involved: it is not obvious at all that in a scientific perspective these would be values *of the kind* that normativism puts forward. For example, it may be that a scientific perspective is *externally* value-laden – because it relies on scientific values concerning hypotheses giving the best explanation – without being *internally* value-laden, that is, without making value-judgements in the definition of the pathological. The distinction between a scientific and an evaluative perspective can be made independently of the issue whether the scientific account is altogether value-free or not.

To summarize the point of view we introduced: Mental disease is both a genuine *disease* – contrary to Szasz's assertion – and a genuine *mental* disease – contrary to the reductionistic thesis. It can be defined as an impairment of mental functional ability. Mental functions are natural abilities which evolve and can probably be determined according to the evolutionary perspective. In addition, the concept of mental illness is defined as a disvalued mental disease.

The scientific perspective leads to a distinction between pathological and normal phenomena. The pathological can be defined as a deviation from a natural norm. It determines the core of medical phenomena, i.e. only pathological conditions may indeed be called illnesses in an evaluative perspective. This is not to assert that medicine is not justified in helping people with problems other than illnesses. The claim is about the concept of illness – namely, that the extension of illness is determined by the extension of the pathological –, not on the proper scope of medicine.

But to say that a certain condition is pathological does not establish whether and why this situation might be harmful. This needs to be clarified from an evaluative perspective. From this perspective we must address, for example, the important question: who is to evaluate? The person himself or herself, the doctor or the society? Can a person be wrong about his or her

own well-being? Is a person in a specific psychopathological condition able to evaluate his or her condition? These questions need to be asked and answered from an evaluative perspective. Normativists usually differ in their accounts on the question whether the disvaluation is due to society, to the doctor or to the individual. But there is often a clash between evaluations of pathological conditions from the subjective point of view and an "outside" view.

One might think that there is no problem with evaluation at all because to be in a pathological condition is enough to justify the claim that there is a harm which should be eliminated. But this assertion certainly does not convince everyone. There are people who do not accept that they are ill despite the fact that they have a disease. Several psychiatric patients reject the evaluation of psychiatrists or relatives and say that they do not see themselves as impaired in any way. That constituted one of the points of antipsychiatry: what many people regard as harmful does not necessarily agree with what the person in question himself or herself thinks. Consider, for example, the following statement of a psychiatric patient: "Gee, you know, they're telling me this is a disease. If it's a disease this is the one I want to have" (Farber 1993, p. 95). What should we say in a case like this? Should we say that the patient's own judgement does not count by definition because he or she suffers from an impairment of his or her mental faculties?

What we need, seen from an evaluative perspective, is a convincing argument why these people might be wrong in the judgement of their own well-being. This is a tall order since it seems to demand an objective account of human welfare. One might argue that some normativists do not take their normativism seriously enough on that particular point because they usually define 'harm' relative to the standards of the culture the person lives in (Wakefield 1992). But an account of why a pathological condition is harmful to the person in question should start from the evaluative perspective of a particular individual. It may be that there are convincing arguments against the subjective evaluation of the patient. But, after all, the concept of harm is as much in need of clarification as the concept of disease. It points to another genuine philosophical problem of psychiatry.

The essays

The first two essays, although focusing on different topics, both reflect on the relation of psychiatry and philosophy. According to these essays, neither discipline is taking over the role of the other but is standing in a relation of complementation.

Lou Marinoff, author of the highly-acclaimed books *Plato, not Prozac!* and *The Big Questions: How Philosophy Can Change Your Life* reminds us of one of the oldest possible uses of philosophy, namely, to help us to lead

our own life in a meaningful way. Philosophical counselling is the fairly new term for this traditional way of seeking guidance in wisdom. Often, people do not only have problems in life which demand medical treatment but they also ask for moral or – generally speaking – spiritual advice. Being engaged in philosophy is practising wisdom; it is to exercise reason. In "Thus Spake Settembrini: A Meta-Dialogue on Philosophy and Psychiatry", Marinoff introduces the potentials of philosophical counselling. But he also delineates it from psychiatric treatment and defends it against a particular reproach by a psychiatrist in which he was likened to a character based in the novel *The Magic Mountain* by Thomas Mann: Lodovico Settembrini.

In "Ten Principles of Values-Based Medicine", Bill Fulford shows how philosophical reflection on values, i.e. the theory of ethics, may contribute to a better understanding of psychiatric theory and practice. Medicine is value-based, not merely in its task to deal with patients in a way which accounts for their particular ideals and interests and, of course, moral norms. In addition, the most basic theoretical terms like 'mental illness' are value-laden. That does not imply that there is no use for scientific research on facts in psychiatry, but evidence-based medicine is not sufficient if it is not complemented by its values-based counterpart, since "all decisions stand on two feet, on values as well as on facts". Fulford here draws on a former analysis in his book *Moral Theory and Medical Practice* and several further publications in which he developed an influential and wide-ranging theory. In his essay, he sums up his account in ten principles and helpfully illustrates them with a psychiatric case.

The second section deals with conceptual problems and questions of classification in psychiatry, thereby touching on issues dealt with in theoretical philosophy. The article by Pierre Pichot, "The Concept of Psychiatric Nosology", gives a historical introduction to psychiatric classification of mental disorders from Sydenham to the DSMs. He also focuses on the main theoretical problems of nosology. First of all, there is the question which has already developed a long tradition, whether mental disorders are natural kinds. Then, there are several possibilities of setting the elements in a classificatory system, e.g. one may focus on symptoms or on aetiology. As is well known in psychiatric diagnostics, the problem of multiple diagnoses is also prevalent. Hence, in recent years an alternative to the categorical approaches has been discussed, namely, dimensional models. This may also be related to the different possible aims of nosology, whether it should guide research, ensure reliable and internationally valid diagnoses or else to gain predictive value in giving hints on possible developments and outcomes of diseases.

Next, in "The Legacy of Antipsychiatry", Thomas Schramme scrutinizes the most common objections to the very concept of mental disorder by the so-called Antipsychiatrists – or, as he prefers, "sceptics" –, in particular by Michel Foucault, Ronald Laing, Thomas Scheff, Ronald Laing and Thomas

Szasz. Although they were mainly influential during the seventies, their arguments against the use of supposedly objective, medical language in psychiatry still finds its supporters today. Schramme has developed a topology of the objections in five categories and finds all of them wanting. Nevertheless, he demonstrates why the sceptical point of view is still of use today in order to question an all too easy conceptual complacency and help increase the awareness of the need for a more theoretically minded approach in psychiatry.

Sceptical psychiatry emphasized the fact that many alleged mental disorders are actually positively evaluated signs of distinctions in several cultures. Much seems to depend on cultural influences whether or not a person is diagnosed as mentally ill.

Hans-Jörg Assion deals with this topic by discussing several examples of culturally–laden categories. In most Western countries, common beliefs in possession by demons, witchcraft and magic ideas have now been replaced by medical and scientific language, but in several territories these seemingly naïve beliefs are still popular today. Nevertheless, as Assion argues in "Archaic Concepts for Explaining Disorders", they may serve a function by providing alternative healing practices in certain cases.

Although human beings are obviously similar in being biological organisms of a certain kind, they also differ from each other in developing several ways of describing the world they live in. This has some impact on psychiatry, too, because different cultures find alternative conceptualizations of mental problems. Johannes Thome, in his essay "The Problem of Universalism in Psychiatry", challenges the problem of culture dependent accounts on a more general level. In what way may psychiatry claim to be a universalist discipline? A common way to secure universalism is to focus on our common nature, i.e. to develop scientific, especially biological models of mental illness. However, as Thome makes clear, this approach may suffer from serious shortcomings in the practice of psychiatric medicine. He states that "the daily clinical work and interaction with patients require a sensitivity to the cultural background and personal beliefs of each patient". Hence, psychiatry needs to be aware of possible conflicts between universalism and individualism. Probably the best way is to accept a moderate dualism between theory and practice.

Aisling Campbell, in "Lacan and Psychiatry" introduces the reflection of French psychoanalyst Jacques Lacan. His considerations are especially interesting, as Campbell vividly shows, because he formed a theory which may account for a theoretical background to be used in psychiatric theory and practice by providing a concept which secures against too hasty a reductionism as well as being adjustable to neuroscience. The combination of neuroscientific findings and psychoanalysis has long been off the agenda, although Freud himself tried to develop his theory – at least at the beginning of his career – in that very direction. In recent years there has been a revival of interest in neuropsychoanalysis. Lacan is particularly important because he focused on the "symbolic

order", i.e. the distinctive ability of human beings to use language and hence provided a way of connecting conscious and unconscious processes.

The third part concentrates on methodological issues in psychiatry and philosophical questions related to philosophy of science. Hans-Jürgen Möller in his "Methodological Issues in Psychiatry: Psychiatry as an Empirical Science" tackles in depth the main theoretical problems concerning the scientific status of psychiatry. Are psychiatric findings to be presented in a law-like or nomothetic fashion? The same problems are to be found again on the more practical side: As already mentioned, different scientific methods and models make for alternative nosological systems. For example, the recent attempt to harmonize ICD and DSM has provided a better reliability at the expense of scientific validity. But Möller's treatise relates to almost all of the contexts discussed so far. The prospects of sceptical objections to psychiatry as well as of reductionism are influenced by its scientific status. He aims at an account of empirical psychiatry in the tradition of *Realwissenschaften* which tries to explain individual events by covering laws and to test theories by exposing them to possible falsification.

Interpreting psychiatry in a scientific fashion might be seen to close the way for the humanities. But, as Johannes Thome states in "Humanities and Molecular Psychiatry", this would paint an artless picture. In recent years, the discipline of "medical humanities" has paved its way and has also a saying in psychiatry. There are many topics in psychiatric theory and practice which cannot be adequately dealt with in merely focusing on biological or even molecular models, especially ethical problems. Again, this does not add up to a demonization of biological psychiatry but points to its possible limitations. Karl Jaspers, the founding father of a humanistic point of view in psychiatry, may well be the suitable classic to turn to.

The tradition of Jasper's *General Psychopathology* today lives on chiefly in phenomenological accounts. But, according to Thomas Fuchs, it would not do justice to its goals if one sees phenomenology merely as way of focusing on first-person data or the subjective point of view. In "The Challenge of Neuroscience: Psychiatry and Phenomenology Today", Fuchs elucidates the possible functions phenomenology may serve in modern psychiatry. One of the main important findings in brain science, namely, neuronal plasticity, calls for a systemic view which sees the whole person in relation to the world. "The brain is essentially a historical and social organ", says Fuchs. By using the examples of embodiment, time-consciousness and interpersonality he facilitates his viewpoint that a scientific outlook need not disregard subjectivity. Hence, cognitive neuroscience is comprehensive only when it has accounted for its alleged adversary.

Dieter Sigmund builds up on the phenomenological approach in "Diagnosis of Core Schizophrenia as an Example of Applied Phenomenological Method-

ology". His article also refers back to the problem of nosology by taking as its starting point the famous assertion of Kraepelin that he has identified a certain disease entity, namely, "Dementia Praecox" – or schizophrenia, as it was later baptized. Sigmund pursues the ambitious task of introducing a much more differentiated way of modelling types of schizophrenia by the method of phenomenology. He consequently introduces several axial syndromes which comprise "core schizophrenia".

The next two essays focus on epistemological issues. Georg Juckel and Andreas Heinz engage with a traditional philosophical question, namely, the problem of other minds. Historically, the fact that we cannot be sure of the thoughts of others has even led to solipsism, i.e. the conviction that only oneself is a conscious subject while the rest of the world may be a phantasm. Although we cannot directly see what is going on in the head of others, we may become acquainted with their feelings by means of communication. In "Can We Know What Others Feel? Anthropological and Epistemological Considerations in Emotional Neuroscience", Juckel and Heinz deal in particular with the role of emotions in trying to understand other people. We often attempt to use emotions for "symptoms" of the inner state of a person. But their outer signs might be based on a "private language" – an assertion the philosopher Ludwig Wittgenstein dealt with. Another question to arise is whether we are indeed able to interpret correctly the emotional reactions of people from other cultures. More precarious for psychiatry, the deductions from emotional attitudes seem to fail with people who are afflicted by certain mental disorders. So when people are emotionally disturbed this "road" to their mind seems to be blocked.

In their essay "On Time Experience in Depression – Dominance of the Past", Hinderk Emrich and Detlef E. Dietrich deal with a peculiar phenomenon in depressive illness, namely, the disturbance of inner time. Time obviously has a subjective side which we experience every day. With the help of philosophy in persona of Michael Theunissen and the neurophysiologist Christoph von der Malsburg, Emrich and Dietrich state the hypothesis that the subjective experience in depression is dominated by the past. They were able to validate their theory by experimental data. Drawing on these findings, they are also able to propose "active forgetting" as therapeutic device in depression. Following Theunissen, they call this the "Proustian method".

Whether we are free to do what we want to do is not only a philosophical question which, till today, is under heated debate but also a very important problem in psychiatry. Whether people are responsible for their doings may also be of interest in juridical trials. Many mental disorders are taken to be paradigm cases of heteronomy, hence philosophers who are interested in the metaphysical and ethical question of freedom of the will tend to use psychi-

atric examples in order to support their theories by empirical facts. The fifth section on compulsion, volitional disorders and freedom of the will sheds light on these issues.

In his essay "Rigidity: The Strange Preference for Compulsion", Martin Löw-Beer acquaints us with a peculiar way of dealing with common challenges of daily life. It seems as if rigid persons explicitly try to reduce their freedom by reducing their alternatives to act. They avoid to choose consciously between options and usually find reasons – even alleged necessities – why they must act in a certain way. Most distinctive in rigid people is that they identify with this behaviour; that they are not alienated at all, hence they are not merely compulsive characters. Nevertheless, Löw-Beer argues their way of living is to be criticized because they totally neglect personal and idiosyncratic values. By seeing himself as executor of what everybody would do in his place, a rigid person loses his individuality and the ability to find orientation in his own life. He does not take a stance of a participant but only an observational point of view.

Addiction may be the most familiar example of compulsive behaviour. In "Towards a Philosophical Anthropology of Addiction", Jann Schlimme tries to give an account of the "inner side" of addiction. The wish to add the subjective perspective of phenomena to the usual medical gaze relates him back to the phenomenological method. After introducing the historical background of our common model of addiction, culminating in Brühl-Cramer's account at the beginning of the 19th century, Schlimme goes on to make use of the famous novel *Naked Lunch* by William Burroughs in order to find an answer to the question: What it is like to be addicted? With Burroughs he maintains that "the algebra of addiction is total need".

The philosophical debate on freedom of the will usually concentrates on the alternatives of determinism and libertarianism. In the last few years, scientists have made a case for determinism which does not seem to allow for human freedom or responsibility. Although the scientific argumentation thereby seems to abandon any significant distinction between compulsion and being "normally" determined, it made a serious impact. Nevertheless, there are already a couple of so-called compatibilists who claim to make good sense of both freedom and responsibility on the one side and determinism on the other. In "Neurophilosophical Perspectives on Conservative Compatibilism", Henrik Walter, who recently published a book on *Neurophilosophy of Free Will*, deals with this debate. He pays attention to the philosophical debate as well as the neurological findings, hence he develops a perspective of "neurophilosophy". In particular, Walter argues for a revised account of moral responsibility, thereby challenging "conservative compatibilism".

Rainer Luthe and Michael Rösler, in "Freedom of Will, Freedom of Action and Psychiatry" transfer the metaphysical problem of freedom of the will to forensic psychiatry where it obviously has its most important applications.

Of consequence to a useful model of criminal liability is the reference to the ability of a person to reason and control. Nevertheless, criminal liability and freedom to act are not the same. What is at issue is the freedom to *will*. The usual slogan that I would be free if I could have done otherwise, is too simple, when the question whether I could have wanted to do otherwise is disregarded. According to Luthe and Rösler, spontaneity is the distinctive mark of the will. Because and insofar "it happens by itself", the will is free.

As mentioned before, many psychiatric disorders have caught the interest of philosophers because they seem to put into doubt widely accepted beliefs about personal identity. Identity disorders therefore form the sixth part of the anthology. First, Thomas Metzinger answers the question "Why Are Identity Disorders Interesting for Philosophers?" They are mostly noteworthy because they may be regarded as empirical test-cases of philosophical theories. Metzinger's own theory of the self, which he developed more thoroughly in his recent book *Being No One*, can account for many psychiatric phenomena. According to him, scientific findings suggest that there is no substantive Ego, a centre in the brain, a ghost in the machine or the like. Rather, the self is a useful fiction, which has evolved by evolution. Since there is no indivisible substance called the self, personal identity is very precarious. Hence, for example, Dissociative Identity Disorder does not pose severe metaphysical problems but is a probable consequence of disturbances in the development of a "self model". In his essay, Metzinger focuses on other psychiatric cases, namely, delusional misidentification syndrome and Cotard delusion, which he uses to put into doubt certain philosophical theses about self-reference, subjectivity and rationality.

Next, Georg Northoff uses empirical material he gained from a survey on people with Parkinson after having been treated by fetal tissue or electrodal brain implants. In "The Influence of Brain Implants on Personal Identity and Personality – a Combined Theoretical and Empirical Investigation in 'Neuroethics'" he also engages with some philosophical accounts on personal identity brought forward by Thomas Nagel and Derek Parfit. The traditional philosophical debate is mainly focused on the question whether diachronic personal identity is constituted by steady relations of conscious experiences or of bodily continuity. Philosophers engaged in this debate tend to use outlandish thought-experiments, so empirical findings on brain implants certainly have an impact by putting philosophy back on a solid empirical basis. Northoff's results do not establish a change in personal identity after transplantation, although there were some alterations in personality, i.e. in individual psychological characteristics. In closing, Northoff suggests anthropological criteria for the impact of brain surgery on personality and personal identity in order to guide ethical questions concerning neurological treatment.

The last section on psychiatric ethics is opened by Hanfried Helmchen, who considers "Ethics as a Focus of Controversy in Postmodern Antagonisms". Acknowledging that modern societies are commonly characterized by a profound value pluralism, the prospects for generally binding moral norms or even trans-cultural, universal human rights seem bleak. But globalization, which directly affects ethical questions in research and treatment, puts the sufficiency of mere regional or national regulations into doubt. In his essay, Helmchen touches on the already mentioned issue of universalism in psychiatry, which, in his context, generates a particular problem of ethics. What we need is a well-founded balance between communal traditions and universal norms. The recent Convention on Human Rights and Biomedicine (CHRB) of the Council of Europe may serve as an example. However, ethics remains in the centre of antagonisms.

One of the main ethical problems in psychiatry is the treatment of patients against their will. Compulsion, coercion and the use of force seem to necessarily accompany psychiatric practice while they often lead to outright opposition to medical interventions. Harald Dreßing begins with an outline of the history of compulsory psychiatric treatment in "Compulsory Admission and Compulsory Treatment in Psychiatry". The growing prominence of patients' rights and the reverence for informed consent led to scrupulous legislative norms for dealing with psychiatric patients. However, according to Dreßing, there remains an inherent conflict between the focus on individual autonomy and the medical impulse to help patients in need and to avoid harm.

In "Coercive Threats and Offers in Psychiatry", Thomas Schramme focuses on instances of possible coercion in psychiatry which are seldom acknowledged because patients have formally acquiesced with a certain treatment. But, he argues, the formation of the stated will might have been influenced by coercive measures which put the validity of the consent into doubt. Most common examples involve threats which are carefully differentiated from morally neutral warnings. He then goes on to consider whether offers can ever be coercive. This seems unlikely because they involve a promise to better the situation of a person without proposing to worsen his or her situation in case of non-compliance. However, Schramme argues that especially in psychiatric contexts there may be cases of coercive offers, in particular, when a dependency of a patient is exploited.

Markus Pawelzik and Aloys Prinz transfer the ethical consideration on a social level. In "The Moral Economics of Psychotherapy" they scrutinize the often stated conflict between economical considerations in medicine and the just distribution of goods according to medical needs. But they argue that this way of constructing a conflict between ethics and economics is ill-considered because medical treatment ought to be efficient in order to be justified. Ethics alone will not do but needs complementation by economic rationality. They go on to apply their thesis to the realm of psychotherapy. Since there is a social

interest in effective treatment, incentives and regulations which influence the conduct of both patients and therapists need to be taken into account.

Altogether, from our point of view, the essays in this anthology show the full potentials of philosophy of psychiatry. They may be regarded as contributions to ongoing discussions but also as starting-points of new debates. Being engaged in philosophy is a never-ending practice. But this is the fun of it.

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