Ethics, Experience, Evidence: Integration of Perspectives in Psychiatry
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*Ethics, Experience, Evidence: Integration of Perspectives in Psychiatry*

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**Abstracts**

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**Invited Speakers**

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**Phenomenology in Psychiatry: The Practice**

To deal with the question of how Phenomenology and Psychiatry might relate in practice, definitions must first be marshalled for both. Given the multiplicity of “Phenomenologies”, it is convenient to specify *ab initio* the approach and themes considered of relevance to the understanding and management of madness (portmanteau referring to what Alienists — now psychiatrists — do). Given that Psychiatry is not a discipline *sub specie aeternitatis*, definitions should be historically contextualized and open-ended. The *raison d’être* of Psychiatry is to understand and manage the mentally afflicted. The fact that it is not a contemplative but a modificatory discipline determines the types of aid that Psychiatry requires.

*Inter alia*, two questions emerge: What can Phenomenology in its current forms offer current Psychiatry? What can Phenomenology in its current forms offer to an idealized form of Psychiatry? By “idealized” it is meant a Psychiatry reconstructed in terms of desiderata as to how societies should conceptualize madness.

The first question poses little difficulty. There is a *de facto* set of issues in ongoing Phenomenology and there is also a *de facto* Psychiatry which in our time is dominated by the biological approach, that is, by the view that the psychological and experiential manifestations of madness are reducible to changes in the brain. Although still active, the psychodynamic, cognitive and social approaches are no longer predominant; in their time, they were subject to interesting phenomenological exploration and the work of Rümke, Binswanger, Boss, May, Schneider, von Gebsattel, Schilder, Frankl, etc. can be listed in this regard.

The epistemological structure of Biological psychiatry is designed to seek correlations between proxy variable representing the brain and proxy variables representing abnormal behaviour. To comply with the medical model, some correlations are re-interpreted as “cause-effect” chains. This reflects the views that some neuroscientists entertain about madness and happens to fit in well with the socio-economic requirements of neocapitalism.

In this Positivist discourse, there is little place for the subtle exploration of subjective experience offered by Phenomenology or for its analysis of the Epistemological role of the Natural Science. This claim notwithstanding, repeated efforts have been made to establish bridges between Phenomenology and Biology, Medicine, Psychology and Psychiatry either by sensitizing the latter four disciplines to some of the preoccupations of Phenomenology or by trying to “naturalize” it.

In its current garb all that Biological Psychiatry requires from clinicians is stable descriptions of abnormal behaviour. How much of the subjective experience of the complainant should be included in these descriptions depends upon neuropsychological theory and upon the power of resolution of the proxy variables representing the brain and the statistical analysis. In its correlational and explanatory work, Biological Psychiatry seems unable to make use of all the information provided by the case notes and by subtle descriptions of subjective experiences. Both current diagnostic criteria (e.g. DSM IV-R or ICD-10) and “scales” and “instruments” to
capture mental symptoms remain based on descriptions first constructed during the
19th century. In other words, diagnosis and aetiological accounts are based on a
fragment of the clinical information already available. Hence, it is unclear whether at
the moment the most pressing epistemological need of Biological Psychiatry is to: a)
improve the power of resolution of both its statistical techniques and of the proxy
brain variables it handles or b) “improve” further the detail and quality of the clinical
descriptions themselves.

It would be fair to say that Phenomenology is more likely to contribute to the latter
than to the former. Indeed, some psychiatrists laud Jaspers because he is believed to
have organized and refined clinical descriptions from the perspective of “Phenomeno-
logy”. This view requires further exploration for it remains unclear whether his work
is just a continuation of 19th century descriptivism or whether he actually made use of
a phenomenological method to achieve his aims. Lastly, on the grounds that cog-
nitivism has made Biological Psychiatry grow in new and exciting directions, others
believe that Husserlian insights can be used to improve cognitive theory. Whether this
can be done without deforming or misrepresenting Husserl’s views remains to be
seen.

The second question is harder to answer. What could Phenomenology in its
present form offer to an idealized form of Psychiatry? A modicum of discontent can
be detected amongst mental health practitioners and the mentally afflicted themselves
about what Biological Psychiatry has to offer. Instituted during the early 19th century,
the association between Psychiatry and Medicine remains contingent and hence sub-
ject to revision. A space seems to be opening to articulate a new view of Psychiatry. It
is expected that Phenomenology should be an active participant in this task.

As a discipline, Psychiatry straddles the human and natural sciences. The former
provide the normative criteria to determine what behaviours are to be considered as
deviant within a particular historical period and the latter try to justify such choices
by seeking to demonstrate putative links between deviant behaviours and specific
brain sites. Part of this enterprise is the transfer of social and symbolic meaning from
the abnormal behaviours to their neurobiological substratum. This reductionistic
move is meant to comply with the anatomo-clinical model of disease that Alienism
(now Psychiatry) borrowed from medicine during the early 19th century.

The objects of Psychiatry can be classified as primary (mental symptoms) and
secondary (diseases). The former constitute the units of analysis of madness and
exploration of their mechanisms of formation suggests that they are also hybrid
objects, that is, consist of radical blendings of neurobiological signals formatted ab
initio by cultural configurators. Mental symptoms are objects with stable ontology and
epistemology. Mental Diseases, on the other hand, are second-order constructs con-
sisting in statistical clusters of mental symptoms. In this regard, they are ontologically
and epistemologically parasitical upon mental symptoms.

The conceptual scaffolding described above is open-ended and allows, inter alia, for
the implementation of whatever new views society may wish to develop to understand
and manage mental afflictions. In terms of its methodology, views on historical
explanation, and themes of interest, Phenomenology is more likely to be of use to
Psychiatry than Analytical Philosophy. For example, it could set for it new objectives
by showing how the experiences of madness can be explored from a variety of per-
spectives. It could also emphasize the need for concepts such as lived-word, horizon,
empathy, dialogicity in relation to the helper-patient relationship, and inter-
subjectivity. Provided that each of these contributions redounds in benefit of the
mentally afflicted all will be well.
To say that a science is value-laden is to say that the theories developed have been shaped by the values of the scientists. Value-ladenness is problematic, first because it threatens the claimed objectivity of science — the idea that scientific communities holding different value-commitments might find fundamentally different results is disturbing. Second, in so far as science comes to be shaped by values that are antagonistic to those without power, this might lead to science that is biased against oppressed groups.

Via considering examples I show that research in psychiatry can be shaped by values in multiple ways. As it is far easier to spot value-ladenness when the values at issue are foreign to us, many of my examples are historical, and are drawn from some work I did looking at debates about race and mental illness in the US between 1890 and 1950. I also draw on current debates, in particular some of the claims made by advocates of “survivor-research”, to make the case that value-ladenness continues to affect current research.

Having shown that psychiatric research can be shaped by values and that this can cause problems I consider how the problems of value-ladenness might be mitigated. I consider and reject various proposals, for example, that researchers should be aware of their values, or that oppressed groups should control research. I go on to argue that the problems of value-ladenness can be minimised by seeking 1) a diverse body of researchers, and 2) a system in which debate is encouraged.

I end on a cautious note. Reducing the problems of value-ladenness is only one amongst other desiderata that we might have for an ideal science. An ideal science would not only avoid bias against oppressed groups, it would also enable us to discover many things, and lead to the development of useful technologies, and be cheap, and so on. The difficulty is that organising science so as to involve diverse researchers and be open to criticism may act against the achievement of these other goals.
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**Ethics: Valuing Mental Health**

A recent critique proposes replacing the individualistic medical ethics approach to bioethics with a public health model (Dawson 2010). The present discussion is about mental health viewed as public, rather than individual, health. Were mental health seen as a public health issue, guiding assumptions about disorder, practice, and policy would change. The application of Dawson’s proposal to mental health is considered here in the context of the distinctive ethical challenges raised by mental health care, and the features of the mental health care setting combining to raise ethical problems of a different order for the clinician, including genuine moral dilemmas, superogatory demands, and entrenched role conflicts, each of which occur on a regular basis.

The advantages and drawbacks of the public health approach to these ethical challenges are illustrated here. In assessing this proposed transformation of mental health care I conclude that only a combination of approaches can adequately protect its sufferers while at the same time attempting to prevent the scourge of mental disorder.

References:
Phenomenology in Psychiatry: The Theory

Phenomenology studies consciousness — in different forms of experience — as experienced from the first-person perspective:
  i.e. as “I” would experience a given perception, thought, emotion, etc.

Psychiatry rests on fundamental “descriptive psychopathology” (cf. G. E. Berrios).

Descriptive psychopathology is (as it were) phenomenology at a distance:
  where we analyze another’s mental activity in some type of mental or personal(ity) disorder.

As psychopathologist, I try to understand the other’s abnormal mental state, to understand what it would be like for the other to experience that state, what it means for the other — where presumably I myself have not experienced that type of mental activity.

Empathy is precisely the form of experience wherein I apprehend another’s form of experience. I do not myself live the other’s experience, but I comprehend it as if I were having such an experience in the other’s stead.

In classical phenomenology empathy is analyzed as a kind of translation from my subjective position to your subjective position as I place myself in your shoes as “I”:
  from my position wherein I have an experience of form “I see …”,
  to your position wherein you have an experience of form “I see …”.

My project here:
  I shall outline an account of how empathy (so understood) is central to both the theory and the practice of phenomenology and, by extension, psychopathology.

• In phenomenology:
  The phenomenology of empathy characterizes that form of consciousness — empathy — wherein I apprehend a form of experience as lived by another.
  Phenomenological reflection is the form of experience wherein I (thus we) apprehend and articulate a particular form of experience as lived.
    I am not actively living through an experience of that form when I reflect on it, describe and analyze its structure.
    Thus, I grasp its structure by empathic apprehension.
  So empathy is both an object of study in phenomenology and the very mental activity we use in the practice or methodology of phenomenology.

• In psychopathology, hence psychiatry:
  It should be obvious that empathic understanding is crucial to our theoretical and practical understanding of various mental disorders — even if they are treated by drugs or even neurological surgery, say, as opposed to varieties of talk therapy that seek to alter the subject’s cognitive and emotional outlook.
  Moreover, the subject’s own capacity for empathy, or lack thereof, is characteristic of various mental disorders.
  As in descriptive phenomenology, so in descriptive psychopathology: we find empathy in two roles, as part of the object of study in mental disorders and as part of the practice of studying those disorders.
N.b.: The psychiatrist’s empathy for the subject’s experience is one thing; quite another is the subject’s own experience of empathy with others.

BACKGROUND:
Edmund Husserl 1912, *Ideas* Book Two, on the many ways empathy appears in everyday experience, applying Husserl’s conception of phenomenology in *Ideas* Book One.
Karl Jaspers 1913, *General Psychopathology*, Volume One, on empathy in the methodology of psychopathology.
DSM-IV 1994, version V with revisions forthcoming, on deficiencies of empathy in various personality disorders.
Workshops

Changing Diagnostic Thinking: Evidence and Values
Organized by: The Swedish Psychiatric Association
Chairs: Hans Ågren and Henrik Wahlberg

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The Human Vision of Diagnostic Utilities to See the Unseeable
During Ancient times and the Middle Ages mental disorders were viewed as supernatural and treated with exorcism. Hippocrates saw a connection between physiological disturbances and mental illnesses. Mental illnesses were described in Persia during the 10–11th centuries and linked to physiological and psychological changes. Pinel introduced human treatment at the end of the 18th century. Kraepelin searched for organic causes but created a nosological classification. Since Kraepelin’s days psychiatric diagnoses have been based to a large extent on symptoms. The main diagnostic systems are the WHO’s ICD-10 and the APA’s DSM-IV.

The ICD-10 is undergoing its 11th revision and the new version will be implemented 2015/16. The DSM-IV is being revised too. Many expert groups have been involved in the development of the new versions but also the general public has been invited to participate (Facebook, Twitter, Blogs, Youtube). WHO and WPA have investigated psychiatrists’ use of and attitudes towards the ICD-10 diagnostic manual. The Swedish survey shows that most psychiatrists are using a formal diagnostic classification. The majority wants the diagnostic system to be understandable to service users and flexible so that cultural variation and clinical judgement can be used — and not just “clear and strict”.

This can be explained by the cultural and humane diagnostic tradition in the Nordic countries (eg. Langfeldt, Retterstøl, Alanen, Cullberg) where the need for strictness has been merged with therapeutic aims, a need for cooperation and ambitions to avoid stigma and self-fulfilment. The Nordic tradition has grown into an international cooperation for a “Person-Centered Integrative Diagnosis” (PiD).

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The Diagnostic Process and Its Impact on the Doctor-Patient Relationship
The diagnostic process in psychiatric practice touches upon numeral philosophical questions with regard to both ethics, experience and evidence. The clinician has to take into account aspects from the realms of both natural and human sciences. This also means that the patient and his/her problem should be viewed upon from a nomothetic as well as an idiographic perspective.

This special predicament gives rise to a necessity to balance between proximity and closeness between the clinician and the patient. The ethical demand as well as the possibility of getting close to the patient’s experience necessitates an initial
proximal position, which later in the process has to be followed by a more distant approach when scientific reflection follows. This exchange between proximity and closeness is a key feature in a successful diagnostic process both with respect to material and ethical aspects.

In this paper I will argue that a good diagnostic process demands a clinician with a sound scientific knowledge but also a capacity to interact with the patient based on general human experiences as well as a deep interest in the patient’s own world.

I will reflect upon the possibilities and pitfalls in the diagnostic process with respect to its impact on the doctor-patient relationship.

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The New Polythetic Diagnostic Universe — Operators and Dimensions in DSM-5 and ICD-11

Classification within psychiatry relies on the classical medical way of viewing natural phenomena as types or categories. A natural grouping of individual entities is a taxon. A monothetic taxon is uniquely classified by one character, shared by all members. A polythetic taxon is characterized by a set of characters: each member has a majority of them, some characters may occur outside the taxon and some members may lack some characters. This is the basis for the use of logical operators in DSM-III from the late 70’ies onward, being based on natural taxonomy. ICD has followed suit.

The line of demarcation between two diagnostic entities, one being “health”, is a useful human artefact. It is connected with what is a clinical “case” — when should a presumed patient be start receiving treatment of some kind. Caseness is a logical construction that utilizes more sources of information than is found in a simple scale or in any other kind of dimensional measure. The caseness concept does not presuppose some area of rarity in a dimensional distribution. It is also dependent on the Zeitgeist.

A psychiatric categorical disorder is a latent structure or class making use of logical operators in the decision-making. An optimal diagnostic procedure will integrate quantitative/dimensional information with other clinical signals, creating an empirical target for treatment. There does exist anamnestic information of non-case-like experiences that might change our categorical understanding of real cases. These experiences may well be subdued subclinical forms of a full clinical presentation, or formes frustes. The argument that this situation is better understood by the use of purely quantitative dimensions (which will allow the development of simplistic cut-off values) is dangerous, since it will be too easy for a clinician to rely on incomplete information before initiating therapy.

Genetic and epigenetic research is expected to help clarify the most optimal way to connect a clinical phenotype with personality traits and adverse environments. I will discuss possible consequences for DSM-5 and ICD-11.
**Psychotherapy of the Psychoses: Evidence and Experience**

Organized by: International Society for the Psychological Treatments of Schizophrenias and Other Psychoses, Swedish section

Organizer: Kent Nilsson, Chairman ISPS-SE

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**Metapsychiatric Analysis of Psychotic Expression**

Prodromes of schizophrenia or prodromes of psychosis are a relatively new and expanding field of interest in psychiatric research. They are seen by some researchers as the initial symptom of having schizophrenia and have become a crucial topic in early psychosis research and intervention.

In this discussion current psychiatric research publications will be presented and my colleagues will also present clinical material and research status in the field of clinical treatment of psychotic experienced. I will try to present some dilemmas in the categorization of experience that could be defined as psychotic/schizophrenic experience. The discussion will be based on results from the thesis *The Prodromal phase of What? A Metapsychiatric Analysis of the Prodromal Phase of Schizophrenia*, (Neubeck, A-K, 2008).

In the thesis research publications were analysed and applied on information given by persons experienced so called prodromes of schizophrenia, and the analysis showed that it was easy to find prodromes or prodrome-like phenomena in all the collected interviews. In addition a second analysis was performed on the material, a phenomenological psychological analysis, showing a more subject-oriented dimension of the interviews. This led to a further aim, analysing what explanations could be given of these phenomena.

I will give examples from the thesis showing that human experience such as long-term abuse, often sexual can trigger psychiatric conditions corresponding to the definition of “prodromes of schizophrenia” as well as “schizophrenia” according to DSM IV and ICD. This means that trauma and/or neglect proved to be a likely partial causal condition of the prodrome-like phenomena or schizophrenia to occur.

However, trauma has not been shown to be a necessary condition for the occurrence of prodrome-like phenomena or schizophrenia in the material in the thesis.

In the discussion of the results some consequences deriving from using different interpretations and explanations of the phenomena will be analysed. I emphasize the value of several dimensions of understanding prodrome-like phenomena as well as schizophrenia and schizophrenia-like conditions, especially as early as the initial phase.

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Therapeutic Needs and Services in a First Episode Psychosis Group in Sweden

Going through a psychosis is always a very overwhelming experience and psychotherapy is one of several services needed after a first psychotic breakdown. There might be different focuses for psychotherapy. The psychotic experience can have opened up different questions about your life and life history, which the client needs and wants to understand further. Traumatic events during childhood and later are overrepresented in persons who experience psychosis. A psychosis can be a part of a difficult separation process in early adulthood, where a family focus might be fortunate. Being afraid of getting re-experiencing scaring psychotic symptoms, or having remaining unwanted symptoms are other problems which can lead you to search for psychotherapeutic help.

The path of recovery differs a lot. Some people have a fast breakdown followed by a swift control over psychotic symptoms and experiences, while others have a slow decrease in functioning and experiencing painful disintegration of the self, often with longer periods of not feeling well. Recovery style can differ from an integrative style with attempts to understand what is happening to you, to a “sealing-over-style”, with more avoidance as a tool to manage your worries. The recovery style can change within a person over time.

To be able to meet the therapeutic needs for a group of persons going through a first episode psychosis, you have to have an organization open for detecting such needs all along the treatment period. A crucial point is to have a respectful idea of the causes of psychotic disintegration, and work closely with the focus of understanding, both the person himself and his close family’s ideas of the cause, without prematurely pressing professional ideas of causes on to the person or his family. Other important needs are of course staff with therapeutic skills, being able to offer different styles of psychotherapy to meet individual needs.

The team for first episode psychosis in Malmoe, Sweden has existed as a specialized team for five years. Some preliminary results from an ongoing study will be presented. How many clients get psychotherapy as a part of a need-adapted treatment model, starting with a family-oriented approach in the initial crisis? Are there special features characterizing this group?

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Processes in Psychoanalytical Psychotherapy of Psychoses — Description of Three Vital and Parallel Processes

Telling giving space in time and room,
treating a person, not a diagnosis
being respected as a person well worth listening to,
giving possibility for telling life-events, feelings, thoughts for sharing the inner world in a safe surrounding.

Creating a coherent and understandable life-history with logic sequences,
causes and effects and demystification of explanations,
hope and confidence to the psychotherapy, to one self and to life itself, an absolute honesty and presence from the psychotherapist.
Developing  becoming a person — the I am me feeling — among others living in the same world as they do

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Psychotic Experiences as Meaningful Information

I would like to give a more clinical vignette relating to experience, in addition to the other contributions from the ISPS. I wish to add to the understanding of the possibilities of psychotherapy. I want in to shed light on how psychotherapy can make possible for unique subjective experiences to get elucidated, and lead to enhancement in the patients capacity to lead her life, albeit not necessarily an easier life.

This paper can be seen as an illustration to what Tomas Rosenlund talked about, that is, how “recovery style” differs in the same person over time. The dread for what was experienced during the psychosis, results in a wish not to have to concern one self with what actually happened, a wish to “seal over”. Coexisting with this there is a wish to get an understanding, a narrative, of what happened, to integrate the experience as an agonizing but comprehensible part of oneself. How this can be done was part of Kent Nilsson’s contribution earlier.

I want to present part of a case material to illustrate this conflict, between the wish to se and the wish to seal over.

I will describe this conflict in a patient, and how the therapeutic situation provided her with a space to dare to scrutinize some of the horrors, and what has held her back earlier. This, as illustrated in this example, leads to regained psychic strength and capabilities.

Integrated in this is the capacity to give herself the permission to acknowledge and reflect on the until now not allowed feelings, and experienced traumas.

However this means she has to consider and take stand to handle situations she never met before, as she escaped them in her earlier way of functioning.

I will in this contribution concentrate on two aspects, which in the therapeutic process in reality is closely intertwined and scarcely can be distinguished:

On one side the staggering between the wish to avoid, respectively the wish to work and understand, the psychotic experiences.

On the other side how the work leads to first an identification of a strong long lasting inhibition and its consequences, and how this in turn lead to, not new remembrances, but that remembrances gets a totally new meaning and relevance. Here experiences of exposure and vulnerability and now also her anger, can be seen as new ingredients. At the same time this is experienced as new abilities of her own. Abilities that earlier was reserved for the rest of mankind, but not for her. This achievement is not only pleasurable.

Facts in this case are changed and distorted, to hinder identification.
Explanation and Understanding: Historical Trends in Swedish Psychiatry

Organized by: Department of Literature, History of Ideas and Religion, University of Gothenburg
Chair: Ingemar Nilsson

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Bror Gadelius and the Tradition of Integrated Psychiatry in the Early 20th Century

Integrated psychiatry is a term that has been given several different meanings but fundamentally it can be seen as a psychiatry that tries to bridge the contradictions that seem inherent in the discipline. In other words, integrated psychiatry emanates from, on the one hand, the recognition of the complexity of the discipline and on the other, the desire to overcome this complexity. The areas subject to integration have varied throughout history but generally they can be linked to the tension between a natural-scientific view and a humanistic one. Although an integral aspiration can be discerned already in the early stages of psychiatry, for example with the French psychiatrist Philippe Pinel, the conflicts between these areas of knowledge have hardly subsided. The opposite tendency, to refine a reductionist approach that completely puts the emphasis on one or the other aspect has rather been the dominant feature through the history of psychiatry.

Early psychiatry in Sweden was strongly influenced by the leading countries in Europe, Germany, England and France and the trends that existed there. Although the actual psychiatric care was highly eclectic, there was a theoretical tendency to emphasize the natural-scientific somatic side, particularly after psychiatry became a university subject in the early 1860s.

When Bror Gadelius (1862–1938) became professor of psychiatry at the influential Karolinska institutet in 1903 all this changed. If the ambition during the 1800s was to legitimize the presence of psychiatry in the medical community by making it as similar to the other medical sciences as possible, Gadelius’s objective was rather to safeguard and develop the originality of the discipline. Psychiatry was dealing with extraordinary problems that needed extraordinary measures. And this didn’t only make the discipline different and more complex than those only dealing with the body, it also made it more advanced, according to Gadelius. The psychiatry he developed was as much psychology as biology and in addition it required epistemological insights in order to avoid the confusion between the areas. Finally, it also had a strong clinical orientation owing to Gadelius conviction that the humane care was the key to the cure of the insane.

Bror Gadelius was without doubt Sweden’s most influential psychiatrist during the first decades of the 20th century, both within medicine and in society at large. His view was therefore of great importance for the contemporary psychiatric development. After his death his imprint on history faded quickly, but the integrative ambition he tried to formulate lives on. In my lecture I will describe this integrative approach and its premises in greater detail and give a few examples of what might be called a Swedish tradition of integrated psychiatry.
Psychoanalytic Influences in Psychiatry

In Sweden, the relationship between psychiatry and psychoanalysis, like in most West European countries, has been subject to discussion since 1911 when psychoanalysis was introduced in The Swedish Medical Association. At times, suspiciousness dissociation, due to distrust, have marked the discussion. During other periods of time an openness have existed that has allowed representatives of academic psychiatry and psychoanalysis to inspire each other. One of the leading Swedish psychiatrists — Carl Henry Alström (1907–1993) — was also a member of the Swedish Psychoanalytic Society. Moreover, he was to hold the professorial chair at the Karolinska Institute. In 1961 Alström initiated a psychoanalytic training program for medical candidates at the newly opened S:t Göran Hospital, situated in central Stockholm. The program was effective up till his retirement in 1973. During their medical training, several influential Swedish psychoanalysts were taught psychoanalytic theory under Alström’s supervision. The account contains an investigation of the nature of Alström’s connections and approach to psychoanalysis.

Psychiatry as a Biological Science

History of psychiatry in Sweden can be understood from different definitions. It can mean the institutionalization of psychiatric health care and the professional growth of a medical specialty. But it can also mean a production of knowledge within academic medicine, psychiatric research. It is evident that the pictures that emerge from these various perspectives are different. In this presentation the stress will be on the scientific developments and on oppositions between them.

Biological psychiatry has constituted a dominant trend within academic psychiatry in Sweden. However, research in psychiatry has generally been poorly supported from extensive public funds. Common for the situations at all psychiatric departments in Sweden after world war II is the strong stress on genetic and constitutional biology, later on from the 1960s also psychopharmacological, biochemical and brain-science research have been an important trend. To a certain degree we can also identify an interest in clinical bedside investigations. On the other hand, interesting psychological and psychoanalytical studies have been very few.

The interest in hereditary factors can be seen in all university departments with Erik Essen-Möller (Lund) and Torsten Sjögren (Göteborg and Stockholm) as pioneers. A few important lengthy follow-up genetic studies with epidemiological and prospective aims have been undertaken by Essen-Möller, Sjögren and their followers. The most creative and influential of Swedish psychiatrists in the twentieth century was Henrik Sjöbring (1879–1956), professor at Lund university 1930–44. He influenced a large group of Swedish psychiatrists — not only in Lund — but he had
very little international impact. Sjöbring put forward a personality theory with four personality variants. The theory was formulated from a biological basis but remained an hypothetical construction with questionable empirical evidence. Finally, the paper will discuss the relations between biologically based research in psychiatry and opposing trends in the second half of the twentieth century.
Mental Disorder and Crime: Evidence and Ethics

Organized by: The Research Group for Philosophy and Forensic Psychiatry (FILUR), University of Gothenburg

Chair: Henrik Anckarsäter

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Mental Disorder as a Cause of Crime — Evidence and Ethics

When media reports about a horrendous crime, the reaction from most people is that the perpetrator must be insane. What other explanation can we found for such a act? The assumption that there is a connection between certain mental disorders and violent crimes forms the foundation for forensic psychiatry. But all violent crimes are not committed by persons who have or would be given a psychiatric diagnosis and only a small portion of people suffering from mental disorders commit crimes. So what can psychiatry tell us about people’s propensity to commit crime?

There are many problems that need to be addressed in this context. To begin with, the statistical data used to show the connection between mental disorders and crime need to be interpreted carefully. For example, the increase in risk as described in epidemiological studies is generally not controlled for co-existing substance abuse and psycho-social marginalization. Secondly, the concept of mental disorder in itself is undetermined. Psychiatric problems defined as mental disorders are end-points of dimensional inter-individual differences rather than natural categories. Deficits in cognitive faculties, such as attention, verbal understanding, impulse control, and reality assessment, may be susceptibility factors that relate to criminal behaviour by increasing the probability for a norm-breaking and aggressive behaviour. Thirdly, attributing causes to complex behaviours such as crimes is not an unbiased process, and mental disorders will attract disproportionate attention when it comes to explanations of behaviours that we wish to distance ourselves from.

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Presenter: Nóra Kerekes

**Childhood Disruptive Behaviour Disorders: Phenotypes, Neuropsychiatric Predictors, and Genetic Background Effects**

**Objectives**

To determine prevalences, patterns of overlaps and genetic background effects for Opposition Defiant Disorder (ODD) and Conduct Disorder (CD) in relation to Autism Spectrum Disorders (ASDs) and attention deficit hyperactivity disorder (ADHD).
Methods
In the Child and Adolescent Twin Study in Sweden (CATSS), parents of 17,220 twins aged 9 and 12 years were interviewed by the “Autism – Tics, ADHD and other Comorbidities” (A-TAC) inventory, including validated algorithms for ODD and CD (AUC=0.89 cut-off for ODD ≥ 3 out of 5 items, AUC=0.90 cut-off for CD ≥ 2 out of 5 items). Main effects of predictors on the scores measuring disruptive behaviors were quantified by Generalized Estimating Equations (GEEs) and the relative importance of specific vs. shared hereditary and environmental effects by quantitative genetic analyses (Mx).

Results
ODD symptoms were overall more common than CD symptoms (between 10-12% vs. 2-5%), and about twice as common in boys as in girls. According to the defined cut-offs, the prevalence for ODD was 3.6% in boys and 2.2% in girls (p<0.0001), and the prevalence for CD was 1.4% in boys and 0.7% in girls (p<0.0001). The overlap between CD, ODD, and ADHD, which is a function of severity, ranges from being a rare feature in children with low-grade to moderate ADHD or with just one or two symptoms of ODD/CD to constituting the rule rather than the exception in severe cases. The strongest predictors of the development of ODD and CD in boys and ODD in girls were: hyperactivity/impulsivity from ADHD and social interaction problems from the ASDs. Interestingly, among girls the attention deficit component of ADHD was the strongest predictor of the development of CD.

Substantial genetic effects were seen behind variance in both ODD and CD, and to a large extent they influenced not only disruptive behaviours but also ADHD and ASDs.

Conclusions
The overlaps between disruptive behavioral disorders are to a large extent due to the severity of problems. Interestingly, prediction and structural equation models suggested that ASD-related problems in social interaction are as important as hyperactivity/impulsivity dimension of ADHD for the development of disruptive behavior problems and attention deficit dimension has the highest significant effect on the development of CD in girls. Longitudinal follow-ups of the study cohort are currently carried out and the impact of the “ASD-Disruptive Behaviour Disorders” complex on the etiology of violence will be explored.

Disclosure
The authors declare no conflicts of interest.

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The precarious practice of forensic psychiatry risk assessments

The use of forensic psychiatric risk assessments is discussed from a clinical point of view, based on the current development in Sweden. A central task in forensic psychiatry has traditionally been to identify dangerous, mentally disordered subjects considered to be prone to commit violent acts. Over time, “dangerousness” has been reworded into “risk”. Nevertheless, such assessments have generally been based on
the type of criminal act committed in combination with the psychiatric factors that characterize the individual patient, while group interaction, situational factors, or social and cultural circumstances, such as the availability of alcohol and drugs, have been largely overlooked. That risk assessments merely have focused on people with a diagnosis of “mental disorder”, and been used as grounds for coercive measures and integrity violations has somehow been accepted as a matter of course in the public and political debate. Even the basic question whether offenders with a mental disorder really are more prone to criminal recidivism than other offenders, seems to have been treated light-handedly and dealt with merely by epidemiological comparisons between groups of persons with broad ranges of psychosocial vulnerability and the general population (and not with different criminal groups). Legal texts, instructions and guidelines from the authorities in charge are often vague and general, while actors in the judicial system seem to put their trust in psychiatric opinions. On the whole, the exchange of professional opinions, general public expectations, and judicial decision processes poses a huge risk for misunderstandings based on divergent expectations and uses of terminology.

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Forensic Risk Assessment, Incarceration and Legal Security: An Ethical Analysis

Forensic risk assessment (FRA) is the activity of using various sorts of information for assessing the likelihood that a person will commit new crimes in the future. FRA is used in most jurisdictions in the criminal legal system as well as in the coercive branch of psychiatric care. Acting on FRA is controversial as false positives interfere with the fundamental liberties of persons. Nevertheless, there is a legitimate case for trying to act preventively in order to avoid major future harm.

This paper investigates the ethical issues raised by acting on FRA. Given that forward-looking concerns of safety and security are defensible reasons for extending or shortening sentences, it asks if the evidence provided by FRA of sufficient quality to be used when applying such concerns without going against basic principles of legal equality and security. The paper argues that acting on FRA would be permissible under high predictive accuracy and impermissible under low predictive accuracy, but its status is much more uncertain when it comes to middle-level accuracy. Regardless of predictive accuracy, however, using FRA is constrained in important ways by the norm of equal legal security. The paper argues that the actual practice of using FRA more with regard to mentally disordered offenders is therefore unjustified.
Nosology and Validity in Psychiatry
Organized by: Centre for Philosophy and Mental Health, University of Plovdiv
Chair: Drozdostoj Stoyanov
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From Kraepelin and Bleuler to ICD and DSM: Conceptual Issues in the Development of Psychiatric Nosology and Diagnosis 1880–2010

Emil Kraepelin (1856–1927) and Eugen Bleuler (1857–1939) introduced two approaches to conceptualizing psychosis that became highly influential for psychiatric research and nosology at the beginning of the 20th century. This paper addresses the historical context of the development of “dementia praecox” by Kraepelin and “group of schizophrenias” by Bleuler, and relates these developments to present day concerns.

A comparison of the two approaches reveals remarkable similarities, but also clinically important discrepancies. An example of a similarity is the assumption that neurobiological factors play a significant role in the etiology of most, if not all psychotic disorders. An example of a key difference is that Kraepelin used the psychotic level of pathology in a formal manner and tended to de-emphasize the idiosyncratic content and biographical context of patient’s symptoms. In contrast, Bleuler emphasized the interpretation of content and of individualizing symptoms. He was among the first within academic psychiatry to apply psychodynamic methods to the diagnosis and treatment of severely disturbed psychotic patients.

The Kraepelinian dichotomy between schizophrenic and affective disorders has been a cornerstone of diagnostic systems in psychiatry for at least 50 years, but that position has been recently challenged on several fronts, e.g. by such notions as “functional psychopathology”, “denosologization” or “deconstructing psychosis”. These new proposals for developing more valid conceptualizations could partly be seen as a reemergence of Bleuler’s model. The continuing implications of these approaches for debates about validity in the ICD-11 and DSM-5 will be explored.

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Limits of Conceptualization in Psychiatry
When investigating the conceptual grounding of psychiatric practice and research, and its concrete expressions in psychiatric nosology, we are constantly confronted with the difficulty of giving unambiguous descriptions or definitions of relevant phenomena. For instance, the concept of psychosis is a central one for psychiatric praxis and research activities, yet its content remains controversial and definitions of
psychosis are often experienced as insufficient by clinicians. Critics of psychiatry often state that this difficulty is symptomatic of the invalidity of the current nosology, while psychiatric researchers excuse it by claiming that psychiatry is still an immature scientific discipline.

In this paper I try to depict how this situation is inherent to psychiatry as a human practice and how psychiatry is both made possible and delimited by its basic conceptual commitments. Psychiatry as a clinical practice grows from a network of concepts and institutions that conceptualize significant deviances from ordinary course of our lives in professionally appropriate ways. But these deviances cannot be distinguished as such but only against the kinds of pre-understandings that are the core of our identities as socially situated human beings. So what is relevant from psychiatric point of view earns its relevance from the specific and contingent forms of life of the respective community. Thus, the content of a “psychiatric problem” remains underdetermined, dependent on situational features and the limits of psychiatric attention are kinetic, constantly changing.

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From the First DSM to the DSM-5: An Epistemological History

The claim that the DSM-III and later editions were atheoretical implied that it is possible to simply describe psychopathological symptoms ordered in diagnostic categories. As the flaws of this approach have become more apparent, the field has entered into a state of crisis. Many important psychiatrists have claimed that the DSM-V should consider not only the refinement of usual diagnostic criteria, but also the possibility of a radical paradigm shift. To better understand what is wrong with the current diagnostic system, we must examine its theoretical assumptions from a historical perspective. The neokraepelinian and neopositivist tenets are discussed to show that:

a) The concept of mental disorder in the DSM-III and later editions is based on the neoempirist liberalization of operative definitions, and the concrete use of polythetic operative diagnostic criteria is responsible for the current anomalies that the DSM-5 will be probably unable to solve.

b) The neo-Kraepelinian view on objects and purpose of a psychiatric classification has entered a state of crisis because current anomalies conflict with its basic tenets. In particular, the neokraepelinian basic tenets that mental disorders are discrete natural entities and that validity has to follow a reliable enucleation at the descriptive level conflict with the evidence that DSM psychiatric disorders are heterogeneous and overlapping and that in the last thirty years validity had not followed the improved reliability.

c) These difficulties call for a radical rethinking of the psychiatric nosology. Possible alternatives will be discussed.
**Mental Disorder. Natural, Practical or Interactive Kind?**

While the concept of mental disorder is at the foundation of psychiatry, there are many fundamental issues unresolved. In this talk, I will assess the popular view that we should conceptualize psychiatric disorders as natural kinds and I will argue that while such a view might be useful in identifying natural substances, it is not an adequate means to conceptualize psychiatric disorders. After defining natural kinds (I), I will draw on historical and empirical material to argue that it is inadequate to think of mental disorders as naturally bounded entities (II–III). Then, I will depart on previous work by Zachar and Hacking and argue that we can conceptualize at least some forms of mental disorder, not as natural, but as practical or interactive kinds. As a last step, I will point out some problems that Hacking’s and Zachar’s accounts encounter and put forward preliminary suggestion towards a definition of mental disorder that is immune to these problems (IV–V).

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**The Converging Validity of the Methods for Assessment and Diagnosis in Psychiatry**

This paper delivers an analysis on how the methods of one discipline (such isolation of genetic markers and biochemical pathways in neuroscience) can be used to validate the constructs of another discipline, namely applied clinical psychology and psychiatry. I begin by contrasting a successful cross-validation between the biological sciences and clinical cardiology (in the case of myocardial infarction) with disappointing efforts to do the same between neuroscience and psychiatry (using bipolar disorder as an example).

What is the possible source of this failure? This question is explored by examining some methodological problems arising from the recent in vivo neuro-imaging studies. The crucial shortcomings include discordance between the functional imaging and clinical assessment (psychological tests). The biological markers may be state dependent and the psychological tests have questionable reliability and specificity. We propose that the biological and psychological measures are considered valid for different reasons, and these reasons are contained within distinct disciplinary matrices. Convergent validation and translation between three disciplines (psychology, psychiatry and neuroscience) would be helpful, but is as yet out of reach.

To make progress on this issue, I propose a novel conceptual model for establishing an integrative dialogue between psychiatry and neuroscience. The goal is to work toward a multi-disciplinary “meta-language” for psychiatry. My model allows

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1 With special acknowledgement for the contribution of Peter K. Machamer and Kenneth F. Schaffner.
trans-disciplinary cross-validation of categories in psychiatry/clinical psychology and neuroscience via simultaneous application of clinical psychological/psychopathological assessment and functional neuro-imaging tools.
**Experience**

In this paper we consider the case of KW from the perspective of "experience", using what we know of her case history to attempt, speculatively, to understand her situation. From the material available on the case of Miss KW we know that in the final year of her life there were several self-harm/suicide attempts through drinking anti-freeze followed by refusal of treatment culminating in a final episode where she indicated verbally and in a note written four days before that she does not want any life-saving measures. We also learn that this happened in the context of "relationship difficulties" and that she had been diagnosed with "emotionally unstable personality disorder" and had been engaging in self-harming behaviour since the age of 15.

It is widely known that self-harm or suicidal acts in this condition are implicated in a complex web of motivations: a way of coping with intense and distressing emotional states; a form of self-punishment; a response to perceived or actual abandonment; a way to mobilise interpersonal responses; and, perhaps, a true wish to die. What was Miss KW trying to communicate first through repeated self-harm/suicide attempts, and second through refusing life-saving treatment? Is it possible to know what she was trying to communicate without consideration of the interaction between her and the clinicians and significant others? An informal term frequently heard in psychiatric contexts to refer to those diagnosed with “borderline personality disorder” is “manipulative”. This implies that the actions of those patients are performed for reasons that transcend what such actions normally signify. The care-givers experience of this engenders a feeling of being manipulated. This creates a general attitude of distrust towards such patients, which the patients experience as an all-too-familiar rejection by those who are providing care and support. Given the poorly developed ability to manage negative emotions characteristic of this condition, this may motivate the patient to engage in more dramatic acts, now perhaps motivated by a desperate desire to engage the care-givers emotionally and practically. Given the complexity and referentiality of such interactions, an act could signify a host of things over and above the implicit meaning it embodies.

In Miss KW’s case, were these repeated self-poisoning attempts a reflection of an enduring wish to die or were they a reflection of a mental disorder of many manifestations a central one of which were recurrent acts of self-harm/suicide? On one hand, if we ignore the diagnosis of “borderline personality disorder”, then Miss KW, arguably, could have done nothing more to express her wish to die. She repeatedly poisoned herself, refused treatment on prior occasions, wrote a letter indicating that she did not wish to be
given any life-saving treatment and, in addition, she was deemed to possess the capacity to make that decision. On the other hand, if we take the diagnosis seriously, then understanding her repeated poisoning attempts and the note she wrote as a straightforward reflection of her wish to die would be a misrepresentation of the meaning of her actions. Instead, her actions would be understood as relational acts and acts of diversion and expression: as symptoms of a mental disorder and not a reflection of an enduring and true wish to die. If this is the case then the mental health act is the appropriate tool to manage the problem, under which she could have been given life-saving dialysis.

There are no easy solutions here: if we adopt the first approach we would be respecting her expressed wishes while ignoring what we know about the disorder and its potential impact on the doctor-patient relationship that forms the basis of capacity assessment. If we adopt the second approach we would be contravening her explicit wishes and intervening on the basis that either the disorder undermines her mental capacity, or is of such a nature and degree as to warrant treatment under mental health legislation, irrespective of her ability to decide.

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**Evidence, Rational Belief and Rational Decisions**

Evidence can be understood as that which justifies rational belief. In the case of KW, the crucial belief of the treating physicians in making their decision was that Miss W retained her capacity to refuse medical treatment. Reconstructing the available evidence, this paper will examine the extent to which this belief is supported by the evidence, and the implications of this for rational decision-making. There are, of course, further questions about the ethics of this case and the priority of morality over rationality, but these questions lie outside the scope of this paper, which is given as an attempt at a clear view of the rationally justifiable implications of the relevant evidence in this case, and will remain silent on moral considerations.

Mental capacity can be viewed in terms of a patient’s ability to understand, appreciate, reason and communicate information relevant to deciding on whether to accept or decline a proposed treatment for medical or psychiatric disorder. Appreciate and reason map respectively onto the terms use and weigh in the Mental Capacity Act [2005]. Understanding and communicating are more relevant in circumstances involving cognitive impairment and are relatively easy to assess. Mental incapacity in those with personality disorder is more likely to be a consequence of failure to appreciate the current circumstance and benefit (or risks) of proposed treatment strategies and ability to reason with the information, which might be disturbed by pervasive patterns of behaviour or emotional response (i.e. a long-standing difficulty accepting the care that has been sought).

Despite the high prevalence of personality disorder in community and hospital settings and the relative frequency of presentations similar to Miss W, a robust evidence base is lacking for the determination of incapacity in these individuals.
Furthermore, the ego-syntonic nature of personality disorders makes it particularly difficult to accept the appearance of rationality as evidence of intact reasoning abilities.

Miss W's ability to understand and communicate her decision were established by her contemporaneous refusal of treatment and supported by her note, drafted prior to her ingestion of antifreeze. While the note was not considered to be a legally binding document, the coroner maintained that it constituted “powerful evidence of [her] wishes and intentions.” Nonetheless, we argue, given Miss W's history of personality disorder, evidence relating to her mental health has an inferential priority over evidence of her capacity: it is impossible to determine the extent to which Miss W retained her reasoning capacities without first establishing the presence or absence of mental disorder at the time of her decision. Bearing in mind the time-constraints and other obstacles to a psychiatric consultation that may have been present at the time of admittance, it is possible that sufficient evidence to draw reliable conclusions about Miss W's mental health in relation to her capacity was simply not available to the treating physicians. From a perspective of rational belief, therefore, neither the belief that Miss W retained capacity nor the belief that she lacked capacity would be fully justifiable on an evidential basis. There would remain, however, a rational basis on which to make the decision, in consideration of its consequences: assuming a lack of capacity and proceeding with treatment is a reversible decision, whereas assuming capacity and respecting the refusal of treatment is irreversible. From the perspective of rationality, the more prudent decision in the face of indeterminate evidence is that which is reversible.

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Ethics. The Judge Speaks in the Name of Law But the Doctor Must Speak in the Name of Compassion

Conflicts within medical ethics over refusal of treatment are often analysed as conflicts between values of beneficence (or non-maleficence) and autonomy. Within this approach arguments in support of involuntary treatment are usually understood as giving primacy to beneficence over autonomy. Conversely, where autonomy is valued over beneficence, respect for refusal of treatment is thought to follow, and thus in the present case would support the decision to let the patient die. This symposium seeks to illuminate and disentangle the assumptions underlying this type of analysis of this difficult case.

The case is particularly interesting because of its power to invoke conflicting intuitions. We explore which features of the case make this so. Questions about mental capacity, the presence of a psychiatric diagnosis, the fact that the harm in question resulted from a suicide attempt, the duties of a doctor and their scope, the influence of the medical environment, and the sheer irreversibility of the outcome all contribute to deeply conflicting ideas about what should have been done. Of these, the diagnosis of personality disorder appears pivotal. In its implicit questioning of the individual’s personhood and values, the diagnosis from the outset challenges her free
will and ability to represent herself. Yet conflict between patients’ and clinicians’ values cannot itself justify failure to perceive a patient as autonomous, or in possession of mental capacity. Assessment of values and motives themselves as pathological, while plausibly motivated by concern for the patients’ welfare nevertheless has huge potential for abuse; thus the diagnosis of personality disorder carries a profound moral dimension, and indeed a potential danger.

It is also the psychiatric diagnosis that places this case in the unique position within UK law of being potentially subject to involuntary treatment regardless of mental capacity, i.e. under mental health legislation. This reveals the complexity of the interaction between morality and law. We discuss arguments that morality has precedence to law. In case of Kerry W, the doctors’ actions were lawful, as confirmed by the coroner. Yet throughout history morality and law have been in conflict. Reflection on the history of medicine and psychiatry in particular reveals abuses, authorised in law and policy, within which the unifying feature appears to be the sanctioning of treatment without consent. We suggest that avoidance of such abuses rests not on adherence to law but on compassion as a source of morality.

We explore the concept of compassion as an alternative to beneficence. As applied in this kind of case beneficence is a paternalistic concept, implying the best interests of the patient may be considered somehow separately from the patient’s own statement of her needs and desires. This approach contains two problematic assumptions. First, we may question the assumption that coercive treatment genuinely serves the patients best interests. After all, the alternative to doing nothing in this scenario was not simply saving the patient’s life, but in its parallel formulation was treating her forcibly, possibly using physical restraint, and in a manner that would in other circumstances—and perhaps in this circumstance—have been tantamount to assault. Second, even if in this scenario involuntary treatment would be the lesser evil, we may question the coherence of describing an individual’s best interests over and above the preferences known to and expressed by that individual. The concept of compassion may be useful first in clarifying what precisely is at stake: on an individual level, the potential to harm an individual under the guise of helping her, and on an institutional level, as suggested in our reflections on psychiatry’s history, the intrinsic potential for abuse of paternalistic institutions. Second, through highlighting what may be done for distressed individuals, rather than what may be done to them, compassion, as opposed to beneficence, suggests that only by striving for the deepest understanding of individuals’ own concerns, in their own terms, will we approach a moral foundation from which to proceed.
Does Phenomenological Psychiatry Have a Future?

Organized by: Association Crossing Dialogues, Rome, Italy
Chairs: German E. Berrios & Massimiliano Aragona

Massimiliano Aragona
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The Recurrent Crisis of Psychopathology and the Future of Phenomenology

The term “Phenomenology” has been used in psychopathology in different ways depending on the theoretical position of the writer.

Since Jaspers’ foundation of General Psychopathology as a self-conscious scientific discipline, a “phenomenological” point of view was used as a reaction to psychiatric models that were considered inadequate because they were not based on the actual lived experiences of the subject.

In the subsequent decades psychopathologists talked of a “phenomenological” approach when they had to face critical points in the development of their studies. A few examples from the history of psychopathology will be discussed here.

Finally, the more recent suggestion to return to “phenomenology” to help the XXI Century’s psychiatry will be discussed in relation to the current crisis of psychiatric nosology, which gives the impression to involve descriptive psychopathology in general. It will be stressed that in this context the meaning of the term “phenomenology” can be different, and that depending on the way phenomenology is intended, different answers to the crisis and conflicting research programs can be proposed.

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Phenomenological Understanding of the Experience of Delusion and Hallucination in Schizophrenics

The question of the comprehensibility of delusion and hallucination in schizophrenics is not only in the center of the question of the essence and definition of these phenomena but also of their causes and therapy.

Here we are concerned only with an understanding made possible by different kinds of phenomenological methodologies (descriptive, eidetic-essence-oriented, constitutive-transcendental, daseins-analytical). We have to differentiate between the understanding or not-understanding of the patient himself, of what he experiences in his delusion and the understanding or not-understanding of the accounts of the patient about these experiences. In this context we have to consider a different delusional experience in the so called primary and in the secondary delusion. (K. Jaspers) The so called incomprehensibility theory of Jaspers relates to the not-understanding of the diagnosticians mainly of the quite alien, uncanny, atmospheric, mostly vague new experiences of the patient in the primary delusion. This incomprehensibility is not so much the case with consecutive delusional ideas of the
secondary delusion, in which the primary delusional experiences are revised by ideas and judgements of the delusional person adapting these in some way to normal reality.

Relating to the primary delusional experiences K. Jaspers speaks of an alteration of existence (Daseinsumwandlung) and of an alteration of the personality in this state. Both alterations are much more lived (gelebt) than experienced (erlebt) by the patient. Here the question arises whether emphatic understanding, applied by Jaspers as a method of understanding, is sufficient to speak of a fundamental incomprehensibility of primary delusional experiences. In this context also the question is important to what extent the delusional patient is at all capable to make his alien delusional experiences understandable to himself and to others. In this way with the schizophrenic person we would rather, but not only, have a problem of intersubjective understanding (Verständigung) than of objective understanding.

For these reasons we assume that a daseins-analytic or constitutional-transcendental approach could give us further possibilities of understanding. These approaches could show us that in the delusion and hallucination of schizophrenics an alteration of the existential a priori (Needleman) as matrices of different modes of being and as such as meaning matrices, or an alteration of categories in the sense of conditions for possible experiences has taken place, which are seen as being responsible for the alteration of their self- and world-experience.

**German E. Berrios**
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**Phenomenology and Biological Psychiatry: Are They Compatible?**

To explore the “Compatibility” of “Phenomenology” and “Biological Psychiatry” it is of the essence to offer adequate and stable operational definitions for all three concepts.

The word “Compatibility” names the quality of those relationships that develop when two or more notions, structures, bodies, entities or systems are brought together, compared, linked or associated. According to the nature of the objects in question and to the reasons motivating the comparison, the resulting compatibility (or incompatibility) can be classed as mechanical, conceptual, logical, mathematical, etc. The degree of synonymity between compatibility, consistency, coherence, agreement, harmony and congruity is yet to be determined.

In its long history, the term “Phenomenology” has been used to refer to a variety of philosophical purviews and to other notions besides (for example, Jaspers’s “atheoretical descriptivism”). In the context of this meeting the term will refer to the Husserlian and post-Husserlian philosophical purviews.

The portmanteau “Biological Psychiatry” can be used to name both the hard claim that brain mechanisms are necessary and sufficient fully to account for all mental disorders and the softer claim that they are necessary but not sufficient to do so.

A positive or negative answer to the question of whether Phenomenology and Biological Psychiatry are “compatible” should therefore depend upon the type of definition chosen for each. This lecture will illustrate this point by showing how combinations and permutations of such definitions lead to different answers.
Quasi-Moral Mental Disorders and Their Treatment

The word “mental” applies to a variety of types of human functioning and states. Consequently, “mental disorders” must be of a similar variety of kinds, and cannot all be dealt with in the same way. This paper concentrates on one kind, which I call “quasi-moral disorders”. These consist in deviations from norms of interhuman relationships, or at least a departure from expected standards of social interaction. (Personality disorders might be an example). To regard such deviations as psychiatric disorders, however, creates at least the appearance of a paradox. On the standard modern view, psychiatric disorders are considered to be forms of illness, and so, by definition, not to be subject to blame, since they are caused by something beyond the individual’s control. But the “quasi-moral” character of these disorders seems to imply that they are the outcome of the individual’s choice. It is contended that this apparent paradox can best be resolved by shifting our conception of moral choice away from modern (essentially Kantian) ways of thinking, and towards something closer to an Aristotelean model, which is described in the paper. This would imply that, if we are to speak of “treatment” for such disorders, and if such treatment is to be ethically justifiable, it would have to take the form of helping persons themselves to reframe their personal development — a process more akin to education than to standard medical treatment.

Moral Problems with Moral Treatment: Historical Reflections on the Role of Ethics in Psychotherapy

One of the pivotal factors in the establishment of psychiatry as a medical science was the introduction of moral treatment. This novel form of therapeutic intervention was aimed primarily at “moral” rather than “physical” aspects of the patient’s condition. “Moral” factors were often understood to be psycho-social in nature. But they were also often associated with ethics and morality. In the terminological and conceptual quagmire that ensued, the term “moral” became highly ambiguous. Medical writers tended to endorse the more neutral, psychological, sense of “moral”. Yet they also often relied heavily on philosophical influences that stressed the importance of “moral” matters in an ethical sense. This led to ambiguities and paradoxes as psychiatry sought to establish its status scientifically, while at the same time borrowing heavily from philosophy.
Many patients claim to acquire insights in psychotherapy but there is little discussion about the criteria that could be used to evaluate them as true or false. Recent analysis of insight-oriented psychotherapy has endorsed a moderate skepticism and raised the conceptual possibility that the benefits of some “talking cures” might be enhanced placebo effects. Instead of acquiring veridical, truth-tracking insight into the nature of their problems, patients may acquire theoretical fictions, artifacts, subjectively satisfying stories, or useful cognitive tools that may still promote psychological healing (Jopling 2008). Call this the moderate skeptic’s challenge. Taking a cue from Saks (1999) argument from patient rejection, I aver that patients should, and likely would, reject a model of psychotherapy that offers them insights that do not purport to be plausibly true. But an objective relation to truth by which the standards for self-knowledge are detached from the person who seeks it does not, I suggest, capture the transformative relation to meaning and behavior at which insight-oriented psychotherapy aims. I present a responsibilist, virtue epistemological response to the moderate skeptic’s challenge. I argue that psychotherapy can and ought to be guided by certain epistemic commitments that may better enable the patient to acquire insights that are plausibly true. In striving to know ourselves, we need more than a theory by which we can distinguish true from false propositions. We need to cultivate the intellectual virtues that can optimize the epistemic capacities of those who must regulate the inquiry. Psychotherapy should involve the responsible reflective agency of patient and therapist alike.

References:
Integrating Perspectives: An Open Discussion of the Problems of Communication and of Understanding between Clinicians and Service Users

Organized by: Jan Verhaeg, Nancy Nyqvist Potter, Tim Thornton,

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16.30–16.40: Nancy Nyquist Potter welcomes the participants to the workshop and introduces them to the background ideas and format. Potter argues that, in order for genuine integration to occur between service-users and professionals, a different sort of communication must be developed. One thing needed for that to happen is that a cluster of concepts must be understood as working together: voice, perspective, and responsibility. She identifies some barriers to communication and some character-traits necessary for it. Potter encourages this workshop to be a space where we can talk freely about problems in communication between service users and professionals.

16.40–16.50: Service-user Jan Verhaegh explains the urgency of this workshop and others like it, to promote better communication, to honor what is life-saving about psychiatry, and to heal from wounds built into the history and structure of psychiatry. Verhaegh discusses ways that service-users and professionals are different and explains why those differences matter. He points out that no INPP groups is organized to promote ongoing service-user/professional communication that is both healing and forward-looking, and he opens discussion for ideas about what is needed for that to occur. In particular, he encourages the discussion of trauma, truth, and reconciliation for collective and individual traumas.

16.40–17.00: Tim Thornton summarizes the issues raised in Potter’s and Verhaegh’s comments, remarks on the importance of this event, and raises some questions for participants to consider. Thornton also discusses his experience with communication with service-users on a collective level.

17.00–17.50: Open discussion among participants. Potter facilitates.

17.50–18.00: Concluding comments by Tim Thornton.
**Oral and Poster Presentations**

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**Pain Talking**

Psychiatry places the origins of pain in a dichotomous position, namely, the traditionally dualistic concepts of physical and mental. Pain is a physical sensation invoking suffering. Psychosomatic pain is classified as an expression of psychosocial stress, or as displaying medically unexplained symptoms. These are symptoms that are inconsistent with an identifiable medical diagnosis. The causal model of medicine requires a physical origin of pain. Pain that is defined as psychopathological pain is considered to be a mood state. In somatization, it is imperative that the meaning and experience of pain is expressed and understood. Narration of people’s experiences of pain can reveal the organization and structure in which their symptoms manifest, enabling the “witnessing and helping to order the experience to be of therapeutic value” (Kleinmann 1989). This poster/presentation emphasizes the importance of constructing the narrative of a person’s experience of pain. In narratives, the meaning of pain is dispersed away from its origin, therefore annihilating the necessity for classifying pain as physical or mental. Instead, narratives need to be examined, as if they are the body of the mind, the revealer, and locus, of the relationship between the person and their pain. As an example, this presentation explores poetry, using the example of isibongo poetry by Sangomas (traditional healers) in South Africa. A poem is after all, in the words of Jonathan Culler, “not simply a series of sentences; it is spoke by a persona, who expresses an attitude to be defined” (2005). Such poetry permits incompatibilities between different types of pain — physical or psychosomatic — to be irrelevant, and consequently the sharing and recognition of pain is dispersed through the communication of verse. Psychosomatic pain transcends the boundaries of the individual through the development of poetry, offering a role in medicine to discuss medically unexplained symptoms independently of the categories of physical or psychosomatic pain.
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Hypermodernism in Psychiatry  
In a seminal 2001 paper, followed by a book in the Oxford University press series named “International perspectives in philosophy and psychiatry”, Bracken and Thomas called for psychiatry to develop into a “postpsychiatry”. Acknowledging the significant progress achieved through modern psychiatry, they envisioned increasing awareness of context, skepticism to the meta-narratives (“grand theories”) of modernistic science, and emphasis on ethics over technology, specifically as related to coercive care and societal interests taking precedence over individual needs and rights. Using these principles to approach issues in psychiatric diagnostics, including its use in legal contexts, I have argued for a rigorous interpretation of what empirical psychiatry can actually inform us on, for dysfunction and subjective suffering as measures of severity of mental health problems, and for restrictions in special legislations by diagnostics (penal or other). However, the overarching trends in today’s psychiatry are turning in an opposite direction: psychiatry is becoming functionally “hypermodern”. Based on noting but correlations and general assumptions about causality, it is claimed that free will and moral responsibility have been scientifically refuted. Categorical diagnoses continue to be treated as discrete disease entities independent of culture and context, in spite of epidemiological, behavior genetic, brain imaging, molecular genetic, and neurocognitive studies demonstrating that mental health problems are dimensional, dynamic, complex, non-specific, and etiologically heterogenous. Even if psychiatric assessments of dangerousness were discarded as unreliable and unethical forty years ago, forensic psychiatry has continued to develop new “generations” of risk assessment methods, and in spite of consistent evidence showing that the best predictor of future behavior is previous behaviors, risk assessments become more and more of a priority in clinical psychiatry. Not only “risk” but also other numerical abstractions, such as “quality”, “efficacy”, and “security”, are catch phrases increasingly used to defend industrialized treatment and coercive measures that serve societal rather than individual needs.
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Evidence, Art, and Ethics  
There is growing support for evidence-based medicine, and psychiatry has not escaped this movement. The attraction of evidence-based psychiatry is clear: who wouldn’t want to be able to say that there was good scientific evidence for their diagnoses and treatments? Doubts have been raised about the compatibility of evidence-based psychiatry and psychotherapy, especially when it comes to dynamic psychotherapy. A number of issues have been raised, most of which center on the claim that any successful psychotherapy is too specific to the particular interactions of therapist and patient to be captured by the more general approach of evidence-based medicine. Even the attempts to manualize dynamic therapies are seen as betraying the creative therapeutic encounter. Therapy in this view embodies the “art” of psychiatry, and as art is not amenable to the procedures of evidence-based research.

There is a way, however, to do research that would satisfy the demands for being evidence-based while respecting the individuality and creativity of the psychotherapeutic encounter. This is to use the case-control method, which has become central in fields such as epidemiology, to study the efficacy of psychotherapy.

After outlining the principles of the case-control method, I argue that the way it can be usefully employed in studying psychotherapy is not by trying to manualize a particular form of psychotherapy, which leaves such studies open to the charge that the art of psychotherapy has been lost in the process. Rather it is by taking being in treatment with a psychotherapist as the condition of interest, and studying a matched cohort of people in therapy with people who are not in therapy. In this case we would be measuring not the efficacy of a particular therapy but of a particular therapist. One might see this as akin to coming to a judgment about the artistry of a practitioner. (There might be difficulties about having a large enough sample to reach statistical significance, but this is a technical difficulty, rather than an a priori difficulty with the concept.)

But now that I have shown that there can be evidence for individualized psychotherapy, and now that proponents of individualized psychotherapy do not have to argue from the weak position of such therapy not being something that there can be evidence for, it is time to reconsider the seemingly obvious ethical imperative supporting “evidence-based” medicine. I do this through a discussion of what evidence might show about art — and what our response to that might be.

The case-control method discussed above can be used to study the effects of exposures other than exposure to psychotherapy, and it has been used in that way. Thus the case-control method can be used to investigate whether religious practice can have an effect on well-being. It could also be used to study whether those who went to art museums more than three times a year, for example, had a longer life expectancy and better quality of life than those who went to art museums less than once a year. Now let us imagine that such a study is done and the results show that those who do not expose themselves to art have longer and happier lives. What would we think?
I argue that in the case of art museum attendance that we would not mount a campaign to warn people of the dangers of museum attendance and to warn them about such attendance — even if the study was replicated in a second population. Instead, assuming we did not think there was some specific environmental exposure that was taking place in museums and that could be rectified, I suspect we would say that art was something that was itself valuable to us, and that we might reasonably choose to expose ourselves to it by visiting museums despite the potential risks.

What does this have to do with individualized psychotherapy?

To start with, I accepted that medicine as a practical application of science had an ethical obligation to have evidence for its procedures. Psychiatry, as a branch of medicine, might be assumed to share in this ethical imperative. But psychiatry occupies a unique position, dealing with illnesses that are frequently — and correctly, I believe — called mental illnesses.

This is not a weakness of psychiatry. Psychiatry deals with impairments (illnesses) in our humanity. Psychiatry deals with the full human being, including both the person’s physical and mental aspects. I argue that rather than being problematic, rather than leaving psychiatry torn between two models, neither fully fish nor fowl, that this is a strength of psychiatry. To the extent that as psychiatrists we are dealing with the biological, when we prescribe medications for example, evidence-based medicine is the appropriate model. When as psychiatrists we are dealing with the mental aspect of the person, evidence-based medicine is not necessarily appropriate.

As with visiting art museums in our hypothetical situation above, we might choose to value individualized psychotherapy even if there was no evidence for it, or there was evidence that it did not help in some instrumental sense. I argue that it is reasonable to value psychotherapy in the same way that it is reasonable to value art, and that we do not need evidence to rationalize this valuation. To eliminate individualized psychotherapy from psychiatry, to restrict psychiatry to biological psychiatry, would be to diminish psychiatry. Diminishing psychiatry in this way would diminish our humanity.
Meet any two people with a diagnosis of schizophrenia and you will be confronted by an interesting and somewhat puzzling scenario. For a start they will relate entirely different experiences about their condition and most likely will respond entirely differently to their medication—if indeed they respond at all. The course and treatment of schizophrenia varies so markedly that perhaps we should give up on the concept of schizophrenia altogether.

This presentation will examine the historical perspective of schizophrenia, where we have come and where we are going in diagnosing and treating this disease.

To explore the question of whether or not Schizophrenia as a disease really exists we will need to take a step back in this lecture and look at where the diagnosis of schizophrenia is first made which would be to the Diagnostic and Statistics Manual (DSM). This of course is only one way of looking at it, yet we as clinicians seem to overlook all the other factors that might give a person this debilitating and devastating diagnosis.

Critics make the point that “normal” people also have delusions and sometimes even hallucinations. Such people may never come to the attention of psychiatric services so the question is what separates them from the people who do? During this lecture, I will attempt to answer all these questions to have a thought provoking and perhaps controversial presentation.
The Broward County Mental Health Court — Bridges to the Community

Criminal courts in the United States have typically been concerned with mental illness and mental retardation only insofar as the mental disability of the defendant is raised to question, competency or sanity. The focus of concern in these instances is on legal issues and not as clinical interventions.

The Broward County Mental Health Court was the outgrowth of three converging perceptions. There was a perspective in the community that it was seeing the “criminalization of the mentally ill” where individuals were increasingly arrested for non violent psychiatric acting out. In the past these individuals may have sought refuge in state psychiatric hospitals, community psychiatric drop in centers or other such programs. These however have largely disappeared due to shrinking resources.

There was a law enforcement perception that it was easier and quicker to arrest and book individuals then have them evaluated at a local crisis center or connect them with a local mental health center.

Finally, the overall lack of an adequate community based mental health system of care had led to a highly fragmented system which is largely difficult to access and/or navigate.

The Broward County Mental Health Court was the first mental health treatment court in the country and it opened its doors in June 1997. This lecture will give the history, the inner workings, the challenges and successes as well as the clinical interventions used to divert non-violent offenders out of the jails and back into the community. It will also assist participants in setting up their own mental health courts in their home communities.
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*Emotion, Causation and Responsibility in the Context of Hate Crime Legislation*

Hate Crime Legislation is a contentious issue among legal scholars and philosophers. At the heart of the controversy lies the suspicion that it punishes a certain mental state (“hate”, or rather: “prejudice” or “bias”) that either 1) the agent cannot be held responsible for or 2) it is not the proper domain of legislation. (2 may be argued independently of, or as a consequence of, 1).

A hate crime is an action deemed criminal on independent grounds, but with an additional feature: It’s *motivated* by a certain attitude towards the victim (typically a negative evaluation of the group to which the victim belongs) normally with a certain intention (typically to harm, degrade or instil fear in this and other members of the group). Critics argue that judging hate crime as worse than its non-hate version cannot be based merely on the greater harm caused, or on the intention of the perpetrator to harm a larger group. These factors, it is argued, is covered by legislation already. The only distinguishing mark, then, is the prejudice behind the intention. In order to justify Hate Crime Legislation, we may have to allow that the law distinguishes between motives on evaluative grounds, and that the acceptability of the motive is not reducible to the harm intended or caused by the particular crime in question.

I will focus on a particular question relevant to this issue: How should we understand the “hate” in hate crime? Is it an emotional state, a (false) belief, a normative stance, or what? Can it be said to be part of the causal explanation of the criminal act in a sense sufficient to ensure enhanced moral and legal culpability? In contrasting cases emotion-based explanations are held to *mitigate* responsibility/ culpability. Why not so here? Is this distinction based on a normative assessment of the emotion in question, or can it be done by specifying the relation between emotion, motivation and action? Or does it necessarily involve both factors? To specify the relevant relation between emotion and criminal action is important if we are to define hate crime not merely by what thoughts/emotions the perpetrator may *have* but by the actual *cause* of the crime in question.


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**Concepts of Coercion: Provisional Lessons from Recent Research**

The topic of coercion has a long and contentious history in both political philosophy and medical ethics. This substantial literature centers on two fundamental questions: What is coercion? And when is it justified? In the context of psychiatry there has been a recent upsurge of interest in coercion, with particular focus on the latter question. For example, a number of research groups have been investigating the relationship between coercion and clinical outcomes. But of course such research relies heavily on assumptions about the former question, that of the concept of coercion. Coercion is often tracked in these studies by various measures of “perceived coercion,” in response to the recognition that involuntary legal status is a poor gauge of the presence of coercion. A result of this approach is that empirical research has started to provide an interesting picture of a variety of coercive pressures and experiences. And these newly emerging findings, in turn, underscore the need for further conceptual analysis. The aim of this presentation, then, is to draw out provisional implications for philosophical debates about coercion from recent research in psychiatry.

At the heart of these concerns is the divide between philosophical approaches that take coercion to be the brute imposition of force versus those that view it as the product of intersubjective pressure and threat. The central contention of this presentation is that both sides of this distinction fail to satisfactorily capture the wide spectrum of patient (and staff) experiences detailed in the empirical research. Several closely related issues are at work here, all of which engage staple assumptions within medical ethics. First, it’s commonly assumed that the presence of coercion invalidates voluntary consent. But this principled intuition about the relationship between coercion and voluntariness is complicated by psychiatric research that describes involuntary patients that deny perceptions of coercion and voluntary patients that report coercive experiences. In addition, it’s usually thought that mental incapacity precludes coercion, as coercion requires the overthrow of genuine decision-making. Recent research, though, has shown that patients both with and without capacity are prone to experiences of coercion, a finding that demands further conceptual and empirical investigation. And lastly, there is an on-going debate as to whether offers should be considered coercive, given prohibitions on undue inducement in treatment and research. Research on perceived coercion may provide some guidance on this issue, as psychiatric patients describe feelings of coercion in response to both threats and offers.

These considerations suggest, at the very least, a need for further analysis of the relevance of psychiatric research for philosophical conceptions of coercion. One important, and unresolved, question involves the degree to which the construct of “perceived coercion” maps onto the philosophical notion of “coercion.” And the fact that the relevant empirical findings arise from research on psychiatric patients raises generalization and veracity problems, as there is a complex relationship between psychopathology and insight. This presentation will take up these concerns while providing a first step towards re-examining the concepts of coercion (and related
cluster concepts) upon which normative judgments about the justification of coercive treatment invariably depend.
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The Constitution of Spatial Intentionality and Affection in the Psychotic Experience

In this presentation, continuing with the issues presented in the PPP conferences of Heidelberg, Leiden and Lisbon, I will explore the relation between some features of the psychotic experience (i.e. schizophrenia) and disruptions or anomalies in the constitution of the most basic register of intentionality, with emphasis about those related to the constitution of the animated space (i.e. the Leibraum), which give rise to a non-conceptual account of the core psychotic symptoms. I will conclude that, without a proper phenomenological understanding of the disorders of those core aspects of intentionality, the account of more “cognitive” symptoms of psychosis, like delusions, remains insufficient and misleading.

In some phenomenological conceptions about embodied experience (Husserl, Merleau-Ponty, Varela and Depraz), it is emphasized that the kinaesthetic patterns of the subject are always affectively tuned and that they deploy a peculiar space which configures a milieu, an in-between, which “surrounds” him and configures his most basic navigational environment. This element of experience has to be understood as essential as other basic components of intentionality: affection, tendency, orientation, kinaesthesia, and various forms of apprehension. So, one of the layers of the embodied subject can be conceived as this constitutional “medium” or horizon across which she will experience the world.

The, so constituted, peri-personal space is affectively permeated, as are the kinaesthetic patterns of any given action or gesture, giving to atmospheres and horizons and their inhabiting objects and persons, a defined emotional “palette” which essentially contribute to establish an important aspect of the non-conceptual meaning of experience. In the same way a difference between Körper and Leib is proposed in the phenomenological account of embodied experience, there will be also a difference between the space as a network of neat geometrical coordinates and the “lived” or “animate” space of human empathy, the Leibraum.

The changing repertoire of the vegetative activity of the Leib — its vegetative tone — can be understood as the counterpart of the environment’s objectal and spatial affective variations. The flux of the receptivity-kinaesthesia diad runs always simultaneously with that of the affective valence-vegetative activity diad. It is tempting to propose that the vegetative tone is able to frame and channel the motor pole expressed by the subject through his kinesthesia: being actions or gestures.

In case the subject’s expectations and interests are met during the perception of the object in accordance with his radial anticipatory system, there will appear what Husserl considers to be the “normal” and basic modalization of the experience: certainty.

I suggest that the most appropriate pair for the affective equivalent of the basic certainty/obstructed certainty modalization is the expected/unexpected couple. The “normal” coherent flux of experience occurs in the expected mode as the emotional “covering” of epistemic certainty. This primeval modalization of experience may also
undergo diverse “obstructions”, giving rise to modes like the unexpected or the surprise.

With these categories in mind, I will discuss and debate some ideas of Sheets-Johnstone about the core phenomenological categorization of the psychotic ante-predicative experience and I will suggest the utility of integrate recent empirical data derived from the work of authors like Holsanova and Lenay about the relation between space and meaning.

Finally, some empirical data that support this view will be mentioned.
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**Merleau-Ponty’s Sexual Schema and the History of Body Integrity Identity Disorder**

According to some authors (e.g. Brang, McGeoch & Ramachandran 2008), body integrity identity disorder, also known as apotemnophilia, is a disorder that straddles the boundary between psychiatry and neurology. This claim happens on the basis of a number of phenomenological resemblances between the desire for amputation of a healthy limb and other body-perception-related neurological symptoms, especially asomatognosia. The neurological line of approach is a recent one, and is preceded or accompanied by psychoanalytical, neuropsychological, philosophical, and psychiatric hypotheses. Hormonal, surgical, counselling and behaviour therapy are tried, but there are no univocal results.

Next to its confusing history in which the disorder itself has no fixed identity and is not classified under a specific discipline, the sexual element in it has been an issue of unclarity and controversy, and its absence a criterion for distinguishing BIID from a form of paraphilia. Scholars referring to the lived body (e.g. Hilti & Brugger 2010) — a phenomenon primarily discussed in the phenomenological tradition in philosophy — seem willing to exclude the sexual component as inessential, whereas other authors (e.g. Lawrence 2006) make the comparison with gender identity disorder or transsexualism, and thus focus attention on the sexual component. In this lecture, we outline the history of BIID with a focus on the vicissitudes of the sexual component. Next, we explain a hardly discussed concept from Maurice Merleau-Ponty’s *Phenomenology of Perception* (1945), the sexual schema, and investigate how the sexual schema could function next to the body image in an explanation for BIID.
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**Why Historians Cannot Locate Accounts of Autism in Pre-1943 Psychiatry**

The poster accounts for the inability for historians to find instances of autistic people from psychiatric reports prior to Kanner’s 1943 recognition of autism. Existing book length histories of autism fail to produce accounts similar to autism pre-1943. Literature on autism has identified commonly discussed examples that partially resemble autism by pre-1943 psychiatrists but the examples produced are few in number and the authors suggesting these examples admit they are highly speculative. Given that today autism is considered to cause severe behavioural abnormalities and has a relatively high incidence rate the absence of historical accounts of autism is striking. Answering this question will contributes to philosophical understanding of how psychiatrists use evidence to move from existing classifications to new ones and what difficulties they face doing so.

In this poster I argue that we cannot locate autism pre-1943 because psychiatrists pre-1943 had little reason to report many of the symptoms we associate with autism. Psychiatrists primarily report the symptoms commonly associated with a disorder. Although patients will have symptoms beyond those commonly associated with a disorder, psychiatrists will mention these symptoms much less often, dependent upon the psychiatrists noticing them and having inclination, time and space to write about them. Thus a psychiatrist pre-1943 writing about an autistic person diagnosed as schizophrenic will likely only note symptoms associated schizophrenia that the autistic person happens to have. Those symptoms today associated with autism that were not associated with schizophrenia pre-1943 will be mentioned much less often and much less consistently. Without psychiatrists pre-1943 mentioning the symptoms that today formulate autism in enough detail and number for any specific patient, historians lack the required proof to locate demarcate case of autism from other disorders.

One might suppose that since autistic people often exhibit severe behavioural abnormalities psychiatrists pre-1943 would have created a new category to account for those symptoms. I argue that they did not because the prevalence rate of autistic symptoms appeared very low. Symptoms are commonly associated with a disorder if those symptoms have a relatively high prevalence amongst people with that disorder. New categories are created if symptoms that are perceived to be relatively highly prevalent are unaccounted for by existing psychiatric categories. However, autistic people pre-1943 were diagnosed under other disorders, creating a mixed group of people with and without autism, diluting the prevalence rate of autistic symptoms. Whilst 25% of autistic people might dislike changes to routine, that figure drops to 2.5% if autistic people pre-1943 made up only 10% of a single category which actually consists of people with autism, schizophrenia, learning difficulties and other disorders. Since autistic people were mixed with people with other disorders, the symptoms that we associate with autism would have occurred at such a low prevalence rate amongst that mixed group that psychiatrists never assigned them their own category.

References:
**Getting an Empirical Grip on the “what-it-is-like” through an Investigation of Internal Self-Objectification in Psychopathology and Development — Part 1: Depersonalization Disorder**

Explaining phenomenology — in the sense of the subjective “what-it-is-like” of experience — is the hard problem not only in philosophy and psychiatry, but likewise in all the brain and mind sciences in-between.

A classical debate in philosophy of mind has concluded inherent differences between our subjective and objective modes of understanding which yield an “explanatory gap” between the mental and the physical (Levine 1983) and lead to the irreducibility of experience (Nagel 1974).

Hitherto, this argument has mainly been applied on the disciplinary level for the purpose of refuting or vindicating external objective (i.e., reductionist) approaches to internal subjective experience.

However, the subject-object divide also exists within the single individual: William James (1890) classically identified two ways of experiencing ourselves — in the form of phenomenal self-as-subject (“I”) or as definitory self-as-object (“Me”). Other authors followed in separating pre-reflective and reflective forms of (self-)consciousness by distinguishing for example “core and extended” (Damasio 2000) or “minimal and narrative” self (Gallagher 2000).

This intra-individual dissociation of the senses of self becomes most apparent in (1) the development and (2) the psychopathological breakdown of the first-person given-ness of experience:

(1) **Development** — From infancy through adolescence, abilities of both emotion regulation (e.g., Holodynski & Friedlmaier 2006) and perspective-taking (e.g., Selman 1980) mature in parallel, jointly leading to the development of self-regulation skills and the formation of a self-concept (Damon & Hart 1982) which both feed into phenomenal self-experience.

(2) **Psychopathology** — Internal self-objectification becomes distinctly manifest in depersonalization disorder (DPD): This exquisitely subjective mental illness is marked by non-delusional symptoms of detachment from self and environment, emotional numbing, and feelings of unreality (ICD-10 F48.1 and DSM-IV 300.6).

Considered together, both depersonalization patients and adolescents show a heightened degree of self-focused attention (e.g., Hunter et al. 2003; Ryan & Kuczkowski 1994, resp.), indicative of an objectification of the sense of self. Furthermore, the peak age of onset for DPD has been reported in adolescence or early adulthood (Sierra 2009) and prolonged “soft” childhood trauma (e.g., emotional neglect) has repeatedly emerged as most significant psychosocial predictor for the development of depersonalization symptoms (e.g., Michal et al. 2007).
It is concluded that empirical access to the subjective phenomenological features of experience is possible through an investigation of the intra-individual dissociation of the senses of self as it becomes apparent in phenomena of internal objectification of the self-as-subject. This phenomenal anomaly occurs most pronouncedly in human development (particularly in adolescence) and in psychopathology (most notably in depersonalization disorder).

Accordingly, we are currently running an fMRI study on emotional and self-related processing in patients with chronic depersonalization disorder, aiming to dissect the disorder’s complex phenomenology and to gain empirical access to the subjective “what-it-is-like” of experience.
**Spiritual Awakening and Psychosis: A Case Report**

**Background:** Meditation is widely thought of as beneficial for wellbeing and is now used by many in the west as a coping strategy for psychological stress. However, this case, managed within the Gloucestershire Early Intervention in Psychosis Team, describes how a period of prolonged meditation seems to have led to the emergence of symptoms that fit with a label of psychosis.

The team were concerned to consider the cultural and spiritual values of the patient, their family and the two societies relevant to the case, as well as the research evidence that guides diagnosis and treatment and might elucidate any known links between meditation and psychosis.

Similar cases are described in the literature, though in the main, in those known to be vulnerable to psychosis or where a more transient experience is described.

**Methods**
The report is based on clinical assessment and review of clinical notes.

**Results**
We describe the case of a female in her late twenties; X. X had no previous psychiatric history, no drug or alcohol history and no family history of psychosis. X developed these symptoms during her third month meditating at a Tibetan Buddhist monastery in Nepal. X described auditory hallucinations of God speaking to her, delusional perception, persecutory delusions, thought interference and passivity experiences. X believed that “higher beings” were controlling her mind and body and described these beings as “black angels”. X also believed that the monks and nuns from the monastery were interfering with her thoughts and telling her to become a prostitute. X described how normal sounds had deeper meanings and were instructing her, for example, a bell ringing meant “Yes” and a horn honking meant “No”. Her symptoms started suddenly and progressed rapidly leading to self harm by lacerations to the wrist and a hair pin wound to her chest. Her symptoms were recognised as pathological within Tibet and she was admitted to hospital and transferred back to the United Kingdom with the assistance of the British consulate. She was treated with Quetiapine on her return and made a recovery over two months. She has since had 2 relapses associated with non compliance with medication; the most recent relapse was severe and precipitated by an intensive yoga retreat in India. She is currently treated...
with Olanzapine 20mg. The course of her illness, through relapse and remission has spanned a year and would now fit with a diagnosis of schizophrenia.

X had longed to go to Nepal and India in order to follow a spiritual path. Her mother is an alternative medicine practitioner and her father prefers to live in a yurt for most of the year. Her father has had input from mental health services for depression and feels strongly that the service does not allow adequately for a person’s spirituality.

**Discussion**

This case brought up many issues for discussion, including the threshold between cultural or spiritual beliefs and experiences and pathology, and the skills available in the team to address the complex issues of this case. We wondered whether the team should gain further training in spiritual matters in order to support those seeking spiritual awakening and advice on possible adverse side effects of such a process, particularly for clients, vulnerable to stress and psychosis. This case allowed us to explore the research elucidating possible explanations for these phenomena; such as sleep or sensory deprivation and the elevated serotonin levels that can occur in meditators.
Deep Brain Stimulation and the Human Will

DBS is beginning to be used on an experimental basis for Psychiatric disorders. As such it is part of the newest wave of psychosurgical techniques. Psychosurgery has a bad record in relation to the integrity of the psyche and so I will review its Aristotelian rationale in the thesis that the human soul is a mode of being-in-the-world associated with characteristically human functioning. As such it is a complex relational property of human beings that is quasi-stable and constructed out of an interwoven set of relationships and practices that equip us to think and develop other personal attributes. The neuroscience of psychiatric disorders such as treatment resistant depression and OCD lead us in slightly different directions in theorising what is happening in each case but both are often mentioned as contexts where DBS might be useful. If that is the case then we need to do two things. The first is to avoid the gold-plated leucotomy standard of ethical scrutiny and the second is to enhance our understanding of the mental disorders involved as a breakdown in a three way complex of human adaptation. Adaptation to the human life world comprises the links between a human subject, the world, and the mirror world of meaning. Jacques Lacan identifies the mirror phase in which the mirror to which a human organism relates and in the reflection of which the human brain is inscribed as more than logic or representation and implicating interpersonal resonance and relationships within contexts of discourse. I will examine the conditions in which DBS seems useful and consider the implications of this form of psychosurgery for a conception of human personality and the will. Volition and personality are linked and both are affected by psychological disorders of various kinds but traditional philosophical conceptions of the will deal with the issues quite inadequately and a version of Nietzsche’s approach is needed to do justice to the interaction between DBS and human freedom or self-determination.
The Ethical Goals of EBM

Since its appearance in the medical literature in the early 1990s, evidence-based medicine (EBM) has had a major impact on clinical practice, teaching, research, and health policy-making. Frequently portrayed as representing the “facts” of medicine, it is viewed as a value-free approach to knowing what kinds of treatment “really work.” This theoretical position, however, masks a subtle and implicit ethical imperative. We believe that EBM will tell us which interventions will improve health. Since practitioners must help patients improve their health, they are obliged to practice EBM. A cardinal aim of EBM then, is an ethical one — the responsibility to improve health.

Ethical determinations about what constitutes health, and how to achieve it, are made when researchers and funders decide what kinds of outcomes to investigate, how to investigate them, and why they should be investigated. Implementing EBM in practice implies agreement with these embedded values, whether or not they are made explicit. Worried about top-down applications of EBM, in which its embedded or “upstream” values are used to direct practice and allocate resources, some scholars have called for more inclusion of “downstream” values within, or alongside, EBM — that is, the values of patients, providers, and local communities. In response, EBM developers have indicated a commitment to making research data merely one component of the evidence-based decision-making process, one in which ultimately patients should have final authority. Envisioned this way, strengthening patient decision-making/informed consent, rather than improving health per se, is viewed as the goal of EBM.

In this paper, I will discuss the scholarly debate surrounding EBM’s goal of improving health and EBM’s shift in emphasis towards the goal of strengthened informed consent. Drawing upon data from a qualitative enquiry of scholars involved in the development and debate about EBM, I will argue that EBM is committed to both of these ethical goals. Where they conflict, the more important goal depends on the aim of the intervention. In contemporary Western medical research, where most interventions are evaluated for their ability to improve health by achieving certain health outcomes, adherence to EBM actually means that patients’ values — rather than evidence itself — should ultimately dictate choices amongst treatment options. In a minority of situations, where EBM has been used to identify interventions that are clearly dangerous and have no benefit, these should not be offered in which case, evidence itself directs practice and there is no role for patient decision-making.

Having increased the ethical complexity of the EBM model of practice, we are left with the question of whether EBM would still be judged a success if it did not lead to much in the way of improvements in health, but primarily strengthened the informed consent process. This paper will conclude by arguing that this more nuanced version of EBM’s ethics accurately reflects the dynamics of real clinical practice but undermines the original, perceived need for EBM.
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**Ethical Warrants of Guidelines for Diagnosis and Treatment of Children and Adolescents with ADHD**

Clinical Practice Guidelines (CPGs) are systematically developed and evidence based statements designed to assist the decision-making of practitioners and patients. The prevalence and public health importance of attention-deficit/hyperactivity disorder (ADHD) has led various groups to develop CPGs.

Major controversies around ADHD concern the diagnostic process and the use of stimulant medication during childhood. Questions can be raised how valid the criteria for ADHD are and whether or not it is a disorder. The long-term effects and safety of stimulant medications’ have not yet been well established. The controversies might be connected with philosophical or ethical presuppositions that are implicitly embedded in CPGs.

**Objectives**

To determine what philosophical or ethical issues play a significant role in the diagnosis and treatment of children and adolescents with ADHD?  
To analyze to which extent these philosophical or ethical issues are covered by the relevant Clinical Practice Guidelines (CPGs)?  
To establish if the process of diagnosis and treatment of children and adolescents with ADHD can be improved by explicitly addressing these ethical aspects?

**Aim**

To investigate the philosophical and ethical issues surrounding ADHD that concern health care professionals, patients and their families.  
To establish whether these issues were explicitly or implicitly acknowledged by the developers of CPGs for ADHD.  
To develop a methodology that addresses these issues and can help to improve care for children and adolescents with ADHD.

**Methods**

Purposeful sampling of children, their families, (child) psychiatrists, general practitioners and pharmacists.  
Systematic review, content and concept analysis, interviews, focus groups and score lists will be used.

**Results**

Development of an educational and practical ethical component of or complement to CPGs.
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**Narrating the Habitual Body in the Psychotherapeutic Context**

In this paper, I will outline how certain phenomenological accounts of embodied subjectivity — the habitual body — can enhance narrative-oriented psychotherapeutic approaches where the aim is to help patients fashion a self fit for fruitful interpersonal interactions.

At present, narrative theories of the self prioritize explicit, linguistic (discursive) activity as the sole route to self-understanding at the expense of non-linguistic experience (see Alcoff 2006, Zahavi 2007). However, much of our daily existence and self-knowledge is tacit. So while we explicitly develop our self-conception as story-tellers, we also implicitly develop a self-image as embodied subjects who interact with the world and others in habitual ways, i.e. the hockey player’s ability to flip the puck with her stick without looking, the firm handshake of an executive, or the awkward, pigeon-toed gait of a shy girl.

I will turn to feminist phenomenological theories of embodiment (Grosz 1994, Weiss 1998, Alcoff 2006, Sullivan 2006) to clarify a) what the habitual body is, b) how this body transacts with its social context, and, c) how working with a clinician to make explicit the self-image implicated in the habitual body would both supplement narrative accounts of self-concept, and boost therapeutic goals. Implicit in the habitual body is sense that one is unified and thereby predictable in certain domains (e.g., hockey player) or daily interactions (e.g. the executive’s handshake). It is precisely a unified self that narrative-oriented psychotherapeutic practice aims to cultivate for interpersonal interactions. Hence, building a unitary self-concept from a unitary self-image is another route to fashioning a flourishing interpersonal self.

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On Serotonin and Self-Respect: Puzzles About Attaining Self-Respect from Antidepressant Medications

One criterion of Major Depressive Disorder, as defined in the DSM-IV, is the existence of “feelings of worthlessness.” Unsurprisingly, then, antidepressant medications are often used to diminish such feelings — or, to elevate self-respect. Here, I draw from work in moral philosophy to investigate the nature of the self-respect that can result from antidepressant treatment. Specifically, I show ways in which this self-respect may be both laudable and fallible. This is important for moral reasons: self-respect is considered to be a basic moral good, and thus its stability and correctness are likewise exceedingly morally important.

To understand the nature of the self-respect produced by antidepressants, it is helpful to utilize a distinction developed by moral philosophers such as Darwall: that between recognition self-respect (R-self-respect) and appraisal self-respect (A-self-respect). On the one hand, antidepressants are often pivotal in producing R-self-respect, which is a type of self-respect equally deserved by all persons (simply in virtue of their being rational, conscious beings). This effect seems not only unproblematic, but extremely morally commendable. In this sense, the production of this self-respect by antidepressants is laudable.

On the other hand, antidepressants may work to engender A-self-respect as well. A-self-respect, unlike R-self-respect, is a respect for oneself based upon one’s particular characteristics and achievements. Because it is dependent upon the presence of such characteristics and achievements, it is not deserved equally by all persons. In fact, most philosophers concur that, because of this, certain instances of A-self-respect (for example, too much or too little) can be mistaken and that, in order not to be mistaken, A-self-respect must be based on an accurate perception of one’s own particular qualities and history.

As opposed to R-self-respect, I argue that there are some ways that the A-self-respect produced by an antidepressant may, indeed, be mistaken or otherwise unstable, and thus problematic (I do not argue that it is necessarily mistaken, unstable, or problematic in all cases).

1. The A-self-respect may rest on the wrong types of reasons.
   The reason for the new-found A-self-respect cannot just be that “there is a higher level of serotonin in certain synapses,” at least not under this description. Presumably serotonin levels do not automatically provide evidence of a self that is deserving of (appraisal) respect.

2. The A-self-respect may be directed towards the “wrong” self.
   Within the work of Kramer, DeGrazia, and Elliott, some have argued that “the medicated self” is not one’s “true” or “authentic” self. If this is true, then any A-self-respect produced by antidepressants is presumably respect of what is now a fundamentally different (or, the “wrong”) self.
3. The A-self-respect may be shaky or unstable due to a confusion about the true self. Even if we grant that the self on antidepressants is, indeed, one’s “true” self, there nevertheless may remain, in many patients, a trenchant confusion about whether this is actually the case (see Karp’s *Is It Me or My Meds?*). So, even if antidepressants produce A-self-respect for the right reasons, about the right self, such A-self-respect may still be unstable if the individual on antidepressants fails to believe it is directed towards the right self.
From some clinical experiences, the author comes to find a specific psychological structure in not a few Japanese depressive patients. In this pathology, individuals find it very difficult to be emotionally independent from their social group. The complete unity is totally idealized. The representations of the patients “who would never hurt anyone” is highly valued and they are quite unbearable to imagine if they might have annoyed others. The author has called the pathology as Japanese narcissism. The pathology is closely related to “the melancholic type” (by Hubertus Tellenbach), “the dominant other” (by Silvano Arieti) and “masochistic caretakers” (by Osamu Kitayama). This individual psychopathology is parallel to social pathology. The fact that the boundary between the group and the individual is fragile leads a situation where a group’s psycho-dynamics easily penetrates into an individual’s psycho-dynamics.

The value of self-sacrifice should be highly estimated in many societies. This is also related to religious feelings. Like saints, those who devote themselves to some greater existence have been greatly respected. People might choose them as an ego-ideal in their psychological developments. On the other hand, especially in Western culture the emphasis has been put on the value of individuals and self-assertions. Those who can resist and fight against irrational suppressions from social authorities could be an alternative ego-ideal. This is also the basis of democracy and capitalism. The author thinks that the conflict between these two ego-ideals leads to the severe psychological conflicts in Japanese people.

Bin Kimura, a famous Japanese psychopathologist, once discussed about Japanese society in comparison with Christian society. He claimed that “it is BETWEEN the human-beings that the ultimate subject which absolutely decide how things and actions should be exists”. This is not only a logical presupposition. The actuality of “BETWEEN the human-beings” for Japanese people is completely the same as the actuality of God for believers of Christianity”. In many scientific studies of human mind, biologically determined subjects come first, and then individuals get together and make families, groups and societies. On the other hand, in some phenomenological studies of human experience, the unity of the whole and individuals is thought to be the basic phenomenon, and from where each experience of human consciousness would differentiate. Infants can hardly distinguish their own thoughts or desires from their mothers’. What Bin Kimura pointed out was that this undifferentiated feeling to the unity has some religious importance to many Japanese people. On March 11th, 2011, the destroying earthquake and tsunami hardly struck Japan. The response of Japanese people to the disaster seems to prove Bin Kimura’s insight. Japanese people are well prepared to get involved in devoting activities in moderate manners in the crisis and show their respect to the integrity of the society. (At the same time, Japanese people find many friends all over the world. Of course, there are noble-minded people everywhere and they know exactly what the human society is.)

However, I should mention the other side of Japanese culture. Bin Kimura also insisted that it is difficult for Japanese people to progress through conflicts. I think Japanese people could become quite intolerant of social disagreements and confrontations. Assertive individuals might be considered to be immoral because they could
spoil the harmony of the society. Authorities have fewer chances to be challenged. The most severely damaged area in Japanese culture is politics. We have tendencies to try to achieve just an adjustment of interests among social members in political situations and fail to accomplish radical reformation.

Therapeutically speaking, the abilities for good politics, such as self-assertions, scientific discussion and decision-making are required. It will help us to overcome the crisis.
Randomized Controlled Trials for Complex Interventions?

In evidence base medicine randomized controlled trials are considered to be the gold standard. However, there also has been criticism. It is impossible to compare findings from randomized controlled and naturalistic studies, if patients or treatment in the naturalistic studies seem to be more similar to one’s own patient or treatment (e.g. La Caze 2010). In order to solve this problem one has to have some theoretical conception whether it matters when patients recruited in the randomized controlled trials are somewhat different. In psychiatry diagnostic classifications tend to be based upon what can be reliably observed, not upon possible causal factors and this makes it difficult to use results of randomized controlled trials if patients or treatment are somewhat different.

There are philosophers such as Worrall and Cartwright who claim that randomization does not add much to the evidence and this philosophical position is related to the non-probabilistic concept of causation they are using. However, even if one accepts probabilistic causation Worrall and Cartwright do have a point that one never knows whether unknown confounders are distributed evenly over various study groups in randomized controlled trials.

In practice, one needs to find the best evidence available. Using the example of home treatment teams in the UK, it will be argued that randomized controlled do not add much compared to naturalistic studies, assuming that one records the interventions done meticulously in a naturalistic study. The same probably applies to other complex interventions as well.
Phenomenology vs. Naturalism in Psychopathology

The two authors, one an analytic philosopher, the other a phenomenologist, engage in dialogue on method in the study of mind. Focusing the debate by way of a case study, the analytic philosopher recounts the unreflective development of his approach in studying human temporality from cognitive-science-inspired theory-construction to an analysis of structural features of his own temporal experience when fully engaged in action. He wonders whether he has thus unintentionally stumbled into a naïve “phenomenology.”

The phenomenologist explicates the more systematic approach of the four methodological components of Husserlian phenomenology: (1) self-reflection, (2) direct observation (Anschauung) of one’s own mental life through self-reflection, (3) description of what is observed in self-reflection, and (4) variation of the features of what has been observed to the point at which the experience becomes no longer an experience of the sort under study. The feature(s) whose variation brought about the disqualification of the experience as of the kind under study is then tentatively considered to be an “essential feature.” The phenomenologist emphasizes that he is not interested in the features of a particular experience qua particular but rather only with general structural features, i.e., those features without which an experience would not be an experience of the sort under study.

The analytic philosopher raises a number of questions about the epistemological status of this method, recognizing that they apply equally to his own naïve “phenomenology:”

• Flounders on appearance/reality distinction: falls into an unfounded dualism — or worse: idealism — insofar as assumes features prominent in first-person experience are also prominent in reality. Subject’s time-experience could well be inaccurate representation of way time and timing actually function in living human beings. Makes inadequate provision for possible future integration of biological, psychological, neurological, and experiential data.
• Features selected for analysis are likely to be those prominent in folk psychology, which are in turn unlikely to be most significant for scientific study of mind.
• Intuitions about essential properties more likely to reflect naïve folk-psychological concepts than scientific reality.

The phenomenological philosopher replies:

• Granted, the approach developed by Husserl (and whose method is sketched above) is too “idealistic” in the non-metaphysical sense of restricting itself exclusively to the experiencing subject and objects precisely as that subject experiences them. The limitations of such a phenomenology must be overcome by
incorporating it within more a encompassing theory of the human being as a natural, social, moral, and historical being.

- This more encompassing theory, as conceived by the phenomenologist, will have two levels: (1) a phenomenological description of human life that adopts the orientation of Maurice Merleau-Ponty and others by focusing on the whole of human existence in the world without explicating him or her using the highly developed theories of biology, psychology (even a Husserlian psychology), or sociology, etc., and (2) a theory of human existence in the world that does take over the highly developed theories of biology, psychology (especially Husserlian psychology), and sociology, etc., and interprets the central claims of these sciences to uncover unifying theses at a more general level.
A Stochastic and Personal Brain versus Evidence Based Psychiatry

The ideas of Kraepelin are generally considered the basis of current psychiatric classification systems, including the DSM (Diagnostic and Statistical Manual of Mental Disorders). It was well realized from the onset onwards that any classification needs a firm scientific basis. The DSM, however, is to a large extent an *ex cathedra* (by consensus) construct (Stojanov et al. 2011) and DSM diagnostic criteria are not amenable to Popperian falsification. I will illustrate this contention with major depressive disorder (MDD) and dissociative identity disorder (DID, or multiple personality disorder).

We review briefly diagnostic criteria, brain theories about the pathogenesis (thereby emphasizing life events) and therapeutic interventions of MDD and DID. The central issue of this presentation is what kind of relationship is possible between mental and neurobiological aspects that may become clinically useful. In short: would a neurobiological or any other parameter or marker ever become sufficiently strong to support or falsify the DSM.

My basic assumption is that any emerging (or supervening) mental entity to explain psychopathology assumes a concomitant level of complexity of the brain. This stance (similar to J.R. Searle’s) envisions levels of brain complexity that are both neurobiological and mental. An individually unique mind does not exist without an individually unique brain, containing all important personal information (i.e. memory, experiences and compromising severe life-events) acquired during life. From the observer’s perspective MDD and DID can best be conceptualized as stochastic brain states (Korf 2010). This conceptualization challenges “naïve” evidenced based psychiatry, but accepts inextricably linked personal experiences.

My arguments together lead to the conclusion that diagnostic classification systems should incorporate stochastic uncertainties (“random mood”) that are not necessarily due to a lack of “scientific” knowledge, but might be inherent to higher brain processes. I discuss the apparent irreducibility of psychological processes to cerebral neuronal mechanisms concomitant with ethical implications in the clinical practice.

References:
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Incubator or Institutions in Mental Health? The Testimony of Anti-Psychiatric Initiatives

The presentation will highlight the social responsibility and ethical testimony of anti-psychiatric experiments, both in modern official services and alternative initiatives. The question of why experience of community based service is considered a failure will be raised. The study will compare three projects: Geel, Belgium; Kingsley Hall, UK; and psychiatric reform, Italy. Finally, contemporary anti-psychiatric ideas will be presented in the light of the Icarus Project, United States. The issue of isolation and the creation of an “artificial incubator” in the abovementioned projects will be discussed in the light of existential psychology.

To begin, the main ethical and philosophical questions raised by anti-psychiatric movements in the 1960s will be discussed. This will be followed by a comparative study of the three projects, focusing on the extent to which they worked and the underlying notions that informed them. First, Geel, a longstanding experiment in mental health care, which is diminishing in practice at the moment. Geel’s approach will be discussed in terms of apprehension towards medication and therapy, controversial regulations such as prohibition of sexual contact, control of patients’ trips to the town, and exploitation in work by “host families”.

Next, a portrait of the work at Kingsley Hall community will be presented. An examination of the lack of established relationships between patients and society, the neglect of clear roles between patients and therapists, as well as the tyranny of authenticity and consciousness, will throw light on the results of this experiment. The philosophical idea of replacing “false consciousness” with the “false freedom of madness” will be called into doubt. This project was more prone to lowering ethical standards as a result of the community isolation.

This will be followed by a presentation about the issue of implementation of psychiatric reform in Italy. A comparison between the results in northern and southern Italy will be drawn. The talk will focus on the philosophical notions underlying the successful process of dismantling the hospital-based system.

Finally, the ideas and ethical doubts of modern anti-psychiatry will be covered by reference to the Icarus Project. The prevailing myth presenting madness as Icarus’ wings will promote an understanding of the philosophy of this project. What modern psychiatry might draw from the Icarus Project is the concept of providing a wide choice of information about medications, hospital treatment and the process of therapy, to people with mental health problems. Modern anti-psychiatry seems to stand against the prevailing attitude in psychiatry, which sees a rising number of patients as being “trapped” in the system for years and “degrading” in their social positions. Instead, these services are an attempt to develop areas of self-control, impact and feeling of authorship in patients, getting closer to existential philosophy.
The testimony of anti-psychiatric movements, although demonised, had a great impact on modern, community-based official services. The illusion of solving the problem in isolated, artificial communities might be the reason for the failure of some previous initiatives of anti-psychiatric initiatives. The dialogue of modern health care with ethical issues raised by anti-psychiatric movements should remain open, but should not search for ‘isolating solutions’ or neglect medications or psychotherapy.
The plausibility of the scientific hypotheses in psychiatry and their relevance to research has been a major concern of philosophy of psychiatry. Our understanding of the complex mental/brain processes underlying mental disorders requires distinct levels of explanation. Obsessive Compulsive Disorder (OCD) is a multisystem disorder that affects cognition, emotions, motivation etc. and has been associated with overactivity in a cortico-striato-thalamic circuit. Wakefield asserts that mental disorders are harmful failures of psychological systems to function in the way designed by natural selection. Accordingly, OCD can be understood as an extreme of evolved harm avoidance strategies, i.e. cognitive representations of future scenarios. Additionally, some contend that obsessive-compulsive behavior can be the result of highly disordered signals of a dysfunctional checking and planning module, probably in the frontal cortices.

We will attempt to examine the validity and explanatory adequacy of the above hypotheses: What evolutionary theory describes as evolved harm avoidance strategies/checking and planning mechanisms are meant to be such strategies or modules, selected for the adaptive mental representational content they generate. By mental representations we refer to internal states that represent properties of the world (intentional content), and episodically become available for attention/ cognition/action control. Biosemantics aims to explain and naturalize mental contents that have been selected for their representational capacity/accuracy. We turn to Millikan’s theory to examine if harm avoidance strategies/checking and planning mechanisms can be correctly considered as selected or proper functions. On this basis, we will further consider if appealing to evolutionary naturalism can help us demarcate OCD from “normal” dysregulations of the proposed functions. The fact that biological nervous systems can represent aspects of the world — intentional level — is also linked with the problem of the cognitive architecture of mind — functional level. Proponents of evolutionary psychology advocate a massive modularity thesis, according to which the mind is modular through and through, including the parts responsible for high-level cognition functions like belief fixation, problem solving, planning, etc. We will set the massive modularity thesis against the criticisms proposed by the advocates of the mechanistic approach, who have indicated that crude forms of modularity should be modified due to their failure of recognizing the diverse components involved in performing a cognitive task. By contrast, mechanisms, though bounded systems, are selectively open to and interacting with their environment. In this mechanistic perspective, the neural areas - loops that have been implicated in OCD should not be seen as parts of a single module, but as multi-level, highly complex psychobiological systems in dynamic interactions with patients’ environments. Thus, the mechanistic approach provides a synthesis of the massive modularity thesis and holism.
Compliance versus Freedom — Behind the Choice, Facing the Consequences?

There are many ways to exercise one’s freedom and there is a consensus that “The right to swing my fist ends where the other man’s nose begins.” Matters become more complicated when it comes to your own nose.

1. the integrity of the nose’s owner is in question
2. the demarcation line between my nose and your nose is hard to be agreed upon, and
3. when freedom is not counterbalanced with responsibility

Let us assume that the above reflects the situation when a compos mentis patient decides not to be compliant with treatment and the consequences would affect not only the patient but those around him. In other words, exercising his rights, the patient takes freedom from medications.

The paper addresses the following issues:

1. How philosophical theories of freedom/free choice could be applied for the explanation of such phenomena?
2. How such theories could help for practical purposes in order to understand and to provide pros and cons arguments?
3. How certain psychotherapeutic theories, mainly Transactional Analysis and Existential Psychotherapy, can assist and be implemented?
4. Could the conclusion be not only moral/ethical but would it lead to legal/clinical implications?

Analogies to social and political cases are quoted. Consideration is given to the fact that our tendency of valuing and exercising free will, understood as “relying on self” rather than “relying on support” changes during the course of life.
Pollyanna Syndrome in Psychotherapy — or Pseudo-Therapy. Counseling, Consoling or Counterfeiting?

Pollyanna syndrome, the name being taken from a story of a girl and a book of the same title, literally means “an excessively or blindly optimistic person.”

The occurrence and danger of such — and similar — attitudes in psychotherapy is discussed. Such attitudes may occur both in patients and their therapists. Either of them may say “things will not be so bad...” attempting to console not him/himself but the other party.

The main aim of psychotherapy is to facilitate the changes, taking responsibility and taking decisions. But there are also other aims, identical to those attributed to philosophy in ancient times, namely, “to treat the soul” or, clinically speaking, to provide consolation. This is usually achieved by attributing meaning and purpose to suffering and set-backs encountered by the patients. But how can it be done responsibly?

In the paper, I discuss how the therapist could avoid the trap of being and coercing the patient to be “optimistic, positive, and strong” when the situation does not necessarily warrant such an attitude or the patient is not sincerely inclined to accept such encouragement.

Philosophy may be of help here. Happiness, if not the most popular issues debated, is not identical with recovery and health but comes close. One may apply theodicy, that is, the philosophical attempt to explain and justify the evil existing in God’s world. Another possibility is Ericksonian approach of utilization, paradoxical intervention, using metaphors and hypnotic techniques in order to let the patient come up with his own, intimate resources facilitating recovery. Eventually existential approach to psychotherapy should be employed.

In short, the difference between an ineffective and an effective approach is the difference between being optimistic and being realistic.
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Turning Users’ Experience into Evidence: A Qualitative Study of Service Disengagement

Introduction
Disengagement from mental health service is a common problem, particularly patients with early psychosis. A plethora of evidence has shown that the characteristics of patients who have disengaged from psychiatric services could be identified by quantitative study. But reasons leading to disengagement, a piece of missing evidence, were rarely investigated. As a result, a reductionist account of this problem has long been emphasized. Service disengagement is a complex issue of which a deeper explanation should accommodate users’ experience since it plays a major role. In order to balance the weight between statistical evidence and users’ subjective experience, this qualitative inquiry aimed at investigating the process and reasons of service disengagement from users’ perspective.
Methods
A purposive sample of seven users, who have experienced service disengagement from a specialized outpatient clinic, was recruited in this study. All participants were male with ages between 19 and 28 and diagnosed of having schizophrenia spectrum disorders. In a one-hour semi-structured interview, they were invited to share their subjective experience of disengaging from the service. All interviews were audio-recorded and transcribed verbatim. The first author initially analysed the interviews.

Results
Preliminary results suggested that four different kinds of reasons of disengagement were usually held by the users; namely unsatisfactory service, unacceptable effects, unnecessary treatment, and unavailability of user or carer. It was also found that dissatisfaction related reasons were reported most frequently. Nonetheless, a participant remarked that users would not disengage from the service simply because of unsatisfactory experience unless expectation was attached to it. It is expected that a full analysis will be finished in the next months.

Discussion
In view of the commonest reasons related to dissatisfaction, an unrefined seesaw model is proposed to highlight the relationship between users’ expectation and their experience in understanding service disengagement [Diagram A]. When expectation is more prominent than the subsequent experience, disengagement is likely to happen. The model supposes that facilitators (e.g. psycho-education) can be invented and manipulated to combat against the impediments (e.g. poor insight) so as to move the pivot to left, and thus engagement will probably be maintained. Although service disengagement is a complicated issue, this model may serve as a basis for deriving intervention strategies in preventing disengagement. Nevertheless, a more thorough data analyses as well as further investigation of model application in predicting disengagement from service are recommended.
Mania Illness Experience — The Case of Time, Space and Body Awareness

This presentation aims to address bipolar patients illness experience during mania. Inner/subjective reality of Mania patients differs from objectively valuable and classifiable experience. A simplistic analysis proposes mania experience as opposed to what takes place in depressive episodes, but a detailed scrutiny shows the involved experience, meanings of disease and attitudes toward treatment are of a different kind.

Time & Space
It is commonsensical to claim that time and temporality are changed in mania and depression. Changes in lived time can be considered epiphenomena of an initial change in psychiatric disorders and also a first disturbance, in itself key to a higher-level disorganization.

But time and affective disorders are in themselves phenomenologically complex if we consider their obscure meaning, multitude of criteria and inconsistent reference norms. In addition psychoanalytical, colloquial and cognitive psychology kept instilling comprehensive and explanatory data onto these notions. Many authors attempted to bridge philosophical phenomenology on time and temporality with psychiatric descriptions and taxonomy. Heidegger, Husserl and Merleau-Ponty ideas were drawn to describe this relation, a relation further dissected by Broome, Cutting, Wyllie and many other twentieth-century psychologists and philosophers.

There are fewer descriptions of space in affective disorders. An attempt will be given to describe theoretical background and patients descriptions of changes in their lived time.

Body awareness
Pre-reflexive and reflexive personal experiences are unique in this disease where extreme forms of pleasure and sense of freedom concur with experiences of distress, body disruption, pain and impairment and sense of loss of body integrity. We intend to include patients’ descriptions of such episodes supporting their awareness of time, space and body. Also we’ll be reviewing literature by authors such as Binswanger, Cutting, Fuchs and Zutt and others on body awareness during mania episodes and their remembrance during recovery.
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Why Mental Disorders Can Diminish Responsibility

Mental disorders have an exceptional characteristic: they can lead to diminished responsibility or even complete excuse. For instance, consider an elderly patient who has been admitted to a general hospital because of a hip fracture, and during his first night in the hospital he suffers from a delirium. He accuses his doctor and several nurses in a rude manner of conspiracy and he even hits some of the staff members. As long as the patient’s behavior is understood within the context of a mental disorder (a delirium in this case), the patient is unlikely to be blamed for his unjustified accusations and even for his hitting personnel. The intuition that mental disorders can excuse has also been formalized in criminal law via the insanity defense. Yet, the example about the patient suffering from the delirium makes clear that this intuition extends far beyond criminal scenarios and courtrooms. In everyday clinical care, be it in a general or mental hospital, health care professionals are likely to find themselves excusing patients based on the consideration that a mental condition — somehow — influenced that person’s behavior.

Although the view that mental disorders can excuse is widespread, it remains unclear why it is that, sometimes, they can diminish responsibility. The purpose of this paper is to develop a conceptual framework that helps explicate our intuitions on mental disorders and diminished responsibility. The framework should consist of components that have a prima facie relevance and plausibility with respect to psychiatric symptomatology; it should not require several argumentative steps or commitments to certain philosophical positions or views before one could explain one’s moral intuitions using the framework.

In discussions on why it is that mental disorders exculpate, “free will” has been mentioned as the crucial factor, for instance with respect to the insanity defense. Therefore, in the present paper I take free will as a starting point and I will consider the explanatory power of free will, while staying away from metaphysical discussions on free will and determinism. In conclude that, indeed, free will related factors appear to be helpful in explaining our moral intuitions with respect to mental disorder. Yet, I argue, they are not sufficient. In addition, three distinct factors are required to explain other instances in which we exculpate a person because of a mental disorder. First, sometimes we withhold blame in case a person acts because of an extreme urge (e.g., the urge to steal in kleptomania); second, we may exculpate a person when he acted on a false belief (e.g., a delusional belief). Finally, although more controversial, a person might be excuclpated in case he lacked moral sensitivity — the psychopath could be an example.

The framework I propose, therefore, consists of the following four components: free will, extreme urge, (false) belief, and moral (in)sensitivity. These factors are helpful to explain the various instances in which we intuit that people are (either partially or completely) excused because of a mental disorder. I discuss some limitations of the framework as well.
Evidence-Based Medicine in Context: A Pragmatist Approach to Psychiatric Practice

The increased demand for evidence-based medicine has proven much more challenging for psychiatry than for medicine in general. Among the concerns is a perception that EBM in practice does not appropriately respond to the character and complexity of psychiatric disorders and treatments, as well as the worry that the concept of "evidence" is too narrowly construed. There is also a fear that EBM may encourage a kind of "cookbook medicine". Are these worries warranted, or are they better understood as expressions of the traditional scientific/humanistic conflict, and thus of a disagreement about what mental disorders really are?

My approach to the debate is that of philosophical pragmatism. From this point of view all kinds of knowledge should be understood in the context of particular human practices. Different practices will involve inquiries motivated by different kinds of values (needs, wishes, interests, and purposes). In line with this, clinicians and researchers take part in practices that are linked to different interests. While the purpose of clinicians is to treat (in a fairly broad sense) ill people, the interest of researchers is to find explanations (optimally of a causal nature) for why people get ill.

From a pragmatist viewpoint, a debate concerning the need for information in a certain practice should take as its starting point the context of this very practice. Describing the clinical situation, D. E. Polkinhorne claims:

[I]n actual practice therapists are guided more by their clients' responses to their actions than by the directives of a theoretical position. They adjust their actions to meet the specific needs of each client.

The quote should not be read to imply that scientific knowledge is of little (or no) importance in clinical practice. Rather, we may take it as underscoring the uniqueness of each patient and hence the practitioner’s challenge in using his or her knowledge and skills — which certainly should include being able to incorporate current research evidence — in accordance with the problem(s) in question. As neither medical knowledge nor the practice of clinical skills has a deterministic character, as far as diagnosis and treatment are concerned, continual adjustments rather than a rigid procedure is the norm. As pragmatist epistemology focuses on utility, the practitioner will not primarily be concerned with the question whether some knowledge-claim is “objectively true” or not, but with whether and how some course of action may make a difference to the better for the patient.

In this presentation I set the rhetorical version of EBM aside and focus on the operationalist one. To make the discussion substantial I refer to Straus et al’s highly regarded book Evidence-Based Medicine: How to Practice and Teach EBM, and their five-steps procedure toward “full-blown” practice of EBM. Scrutinising how specific interests are linked to particular steps, I suggest that the EBM procedure may be seen as a tool (rather than “truth”) for clinical practice. And as a tool it will fit perfectly for some purposes and not at all for others.

A pragmatist viewpoint does not imply “downplaying” medical evidence. What it does undermine, is the tendency to present medical evidence as context-free, i.e., as objective and determinate in a manner that is prior to or independent of the claims of
particular interests at stake in a clinical situation. On a pragmatist analysis, medical science would strengthen its trustworthiness by making explicit, as far as possible, the interests involved at all levels. By doing this, it would be easier to address both practical clinical possibilities and the limitations of the knowledge field when making diagnostic and therapeutic decisions.
The Doppelgänger and the “Paired Mirrors’ Phenomenon” in Schizophrenic Monozygotic Twins

Identical twins live through their lives while seeing each other from birth so that one finally recognizes another as one’s doppelgänger in a way. In other words, identical twins may think that looking at each other is a better reflection of the self, which is not reversed unlike the same that one finds in a mirror. They walk through their lives always as a set by complementing one another throughout their life. This phenomenon shall hereinafter be referred to as a “Paired Mirrors’ Phenomenon” in identical twins. In this paper two clinical cases of schizophrenic monozygotic twins shall be presented in order to discuss the unique Doppelgänger Effect and the onset of the “Paired Mirrors’ Phenomenon”, and the role of the aforementioned effect played to cure the phenomenon in the patients’ restoration processes in a psychopathological manner.

Case 1
Identical twins, who primarily had frail egos, have supplemented each other as a Paired Mirrors’ Phenomenon until they were in junior high school; however, they both became emotionally unstable after they moved on to different high schools. The elder twin, which had a weaker constitution, started living on his own after entering university. He ended up committing suicide because of his emotional instability and a social anxiety disorder caused by Paired Mirror’s Phenomenon that had collapsed with his brother’s absence. The younger brother looked at the dead body of his twin and hallucinated that he had transferred to the body of his dead brother. He went through the funeral thinking that it was his own funeral which led to the onset of catatonia due to his acute confusional state. The younger twin admitted that his brother seemed like a visual hallucination of himself, and said that his twin became a baby and came into the younger brother and they became one in a spiritual sense. After that, the younger brother still felt inside of him the non-visual cenenesthetic Doppelgänger. After 4 months of hospital care, he talked about his interpretation of the unification of the Doppelgänger and self-defense mechanisms. He also recognized his development of stronger ego which led him to go on with negative symptoms but no recurrence.

Case 2
There were male identical twins that grew up closely and as a Paired Mirror’s Phenomenon. The younger twin first came in to a hospital at the age of 21, with a diagnosis of hebephrenia. The elder twin, on the other hand, developed catatonia at the age of 24 because of his brother’s admission, which was the loss of the Paired Mirror’s, and was admitted to the hospital four times. When I was in charge of them, they were in the state of chronic devastation and had communication issues when they were 39 years old. The brothers were taken to different wards from their first admissions and they did not share many similar characteristics. For example, the older brother was masculine and good-looking, but had positive symptoms of delusions, hallucinations and water intoxication. On the other hand, the younger brother was thin and had flat affect, and had a main clinical picture of negative symptoms which were occupied with incoherent speech and stereotypical behavior.
However, when they were taken to the same ward after 15 years of separation, even though the younger brother developed an acute illness temporarily, the brothers started communicating gradually as if they recognized one another as oneself in a mirror or Doppelgänger. Their appearance, behavior, and symptoms became similar. This surprised people around them and made them realize that the brothers really were identical twins. Their communication issues and ego functions grew stronger and stabilized after that.

The Doppelgänger effect in schizophrenia is a phenomenon that creates a false ego that cannot holdup in threatening situations because they have not developed coping mechanisms. The phenomenon appeared when one of the identical twins expired and got reproduced as an ideal image in the other twin as a self-image that has a stronger ego and operated during the restoration process in self-medication. Moreover, I consider that the Doppelgänger effect and the “Paired Mirrors’ Phenomenon” of identical twins supplements each other’s frail ego functions and functions as a prophylaxis of schizophrenia or as an effect of reciprocal treatment after the onset. In addition, having patients discuss about the Doppelgänger effect during counselling sessions seems to have reduced the distance between the Doppelgänger and the self and it led to the elimination of the symptoms.
You’re Not Hearing Me! Responding Appropriately to Adolescent Offenders

Patients, in telling of their experiences, are giving testimony in the classic philosophical sense as discussed by Coady. Typically, testimony is evaluated by the likelihood that \( p \), the credibility of the speaker, and the sincerity of the speaker (does the speaker have reasons to deceive?) After briefly setting out these standards for testimony, I problematize them in relation to youth offenders. What happens when clinicians encounter the testimony of an adolescent offender about his or her account of events or perspective on his or her punishment or incarceration? I suggest that clinicians have a tendency to be skeptical when it comes to offenders — and perhaps rightly so. But I will argue, following Miranda Fricker’s cue, that sometimes not to take seriously the testimony of others amounts to an epistemic injustice. That is, sometimes, due to prejudicial biases, the hearer fails to credit the testimony of the speaker, thus depriving him of the status of being a knower. When prejudice distorts one’s hearing, it does an epistemic injustice to the speaker. Sometimes, a hearer (clinician) may have a patterned skeptical response that is not warranted, and the result is that it treats the speaker unfairly as a knower, and thus unethically as well.

To begin to address this tension, I elaborate on Fricker’s claim that hearers need to develop what she calls the virtue of “correcting for an injustice.” In expanding on these ideas, I apply the notion of uptake. Uptake, according to J. L. Austin, is a communicative act that secures the speech act of the listener. I expand on Austin’s notion, by arguing that speech conventions are insufficient to secure meaning because those conventions are themselves shaped by social context. (For example, Marilyn Frye says that women’s anger does not get uptake because it typically is not recognized that she has “spoken.”) The question I am addressing in Section III is what it would look like to give appropriate uptake to adolescent offenders, while averting epistemic injustice and preserving truth-conditions.

Giving appropriate responses to offenders requires that the hearer (clinician) take seriously her responsibility as a receiver of testimony to give a “distinctly reflexive social awareness” (Fricker 91). This involves critical reflection about one’s own prejudices, positionalities vis-à-vis various patients, and a well-developed balance of skepticism and respectful belief. A case will be presented for discussion.
The central role of mechanisms in scientific explanation is widely acknowledged in contemporary philosophy of science, especially in the philosophy of neurosciences and psychiatry. However, it also widely shared that mechanistic explanations are incompatible with law-like explanations, i.e. explanations by means of scientific laws. More precisely, it is argued that the enormous complexity of mechanistic processes underlying human psychopathology and the high specificity of their corresponding mechanistic generalizations are at variance with the strict universality of law patterns and the unrestricted domain of validity of their corresponding law-like generalizations. In the philosophy of psychiatry, this presumed incompatibility has been recently stressed; among others, by the eminent psychiatric researcher Kenneth Kendler in his paper “Explanatory models of mental illness” (Am. J. Psychiatry 2008; 165: 695–702). However, these strict requirements for genuine lawfulness and law-likeness have been challenged not only in the bio-medical and the social sciences but even in the paragon of natural sciences, namely physics. Moreover, even if highly specific, in order to have explanatory power mechanisms should exhibit stability and robustness, at least to some non-negligible extent. Thus, the distinction between mechanistic patterns and generalizations on the one hand, and lawful patterns and generalizations on the other, is only one of degree and not of kind. In my presentation, I will take as illustrative examples the generic law-like generalization the dopamine hypothesis of delusion-formation in the acute psychoses and its mechanistic specification, namely patients’ abnormal salience attribution to neutral stimuli. The analysis of these examples will show that mechanistic explanatory hypotheses are a species of law-like ones, holding under comparatively more restrictive ceteris paribus clauses than the latter. In compensation for their lower degree of generality, specific law-like mechanistic explanations are both epistemologically and ontologically deeper than their generic merely law-like counterparts. Accordingly, they are more genuinely explanatory than the latter which constitute at best mere explanatory sketches susceptible of alternative mechanistic specifications.
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**Explanatory Coherence, Partial Truth and the Distinction between Validity and Utility of Psychiatric Diagnosis**

Among the foundational problems facing contemporary psychiatry, the problem of the validity of its diagnostic constructs, such as e.g. those of schizophrenic or bipolar disorders, remains still not only unsolved but even very poorly understood. As a foundational problem, it involves several core issues in the philosophy of science such as those of realism, truth and explanation. However, expert professionals in the field of psychiatric diagnosis are often oblivious of these broader issues. I will take as an example a recent instant-classic paper (cited already more than 400 times as per Google Scholar) by Kendell and Jablensky, whereby the authors suggest that at least for the time being psychiatric diagnostic constructs should be evaluated on the sole grounds of their utility instead of their validity (*American Journal of Psychiatry*, 160, 2003: 412). More precisely, they stressed the paucity of available evidence supporting the validity of psychiatric diagnostic constructs, in sharp contrast to their high utility, understood as providing “nontrivial information about prognosis and likely treatment outcomes and/or testable propositions about biological and social correlates” (op. cit. p. 9). Moreover, in support of their proposal for a robust distinction between the validity and the utility of psychiatric diagnostic constructs, the same authors claimed that whereas the former is a categorical or an “all or nothing” and context-free matter, by contrast, the latter is a matter of degree and, at least in part, context-dependent. In the following, I will try to show that the validity of psychiatric diagnostic constructs, understood as the degree of factual truth of idealized conceptual models of human psychopathological reality, is also a matter of degree. Moreover, I will argue that the pragmatic utility of psychiatric diagnostic constructs is parasitic on their validity, being one though not the sole of its indicators or criteria. Finally, I will sketch an alternative scientific realist account of the validity of psychiatric diagnostic constructs along with an epistemic index thereof, stressing the need of their integration with mechanistic explanations within an explanatory coherence framework.
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Reference and Evidence in Jaspers’ Phenomenological Approach to Psychopathology

In his classic paper of 1912, “Die phänomenologische Forschungsrichtung in der Psychopathologie”, Karl Jaspers made two apparently mutually inconsistent assertions. On the one hand, he claimed that clinicians’ access to the various types of experiential contents of patients’ consciousness is a direct epistemic process consisting in the “empathic understanding” (Einfühlung) and “co-experience” (Mit-erleben) of these contents by clinicians’ own consciousness. Jaspers conceived of this process on the analogy with the epistemic process of the direct observation in the natural sciences and its presumed infallibility, likening it to the process of vision, however with an “inner eye”. On the other hand, at several places of his paper, Jaspers conceded that clinicians should also have recourse to a variety of clinical indicators of patients’ mental experiences, such as expressive movements or utterances. In other words, Jaspers acknowledged that clinicians’ access to the experiential contents of their patients’ consciousness is not invariably direct but, at least in part, mediated by their respective clinical indicators and thus indirect. I argue that at the root of this logical inconsistency lies Jaspers’ conflation of the semantic category of reference with the epistemological one of empirical evidence, as well as the conflation of both with the psychological category of subjective certainty. More precisely, although the intended reference of the concepts and hypotheses of General Psychopathology are patients’ unobservable types of experiential contents, the justification of their correct application in each particular case is grounded in the evidence provided by their observable clinical indicators along with their empathic resonance in clinicians’ minds. Moreover, whether direct or indirect, psychopathological hypotheses about patients’ mental experiences are always fallible and thus in need of rigorous testing for accuracy, however subjectively certain clinicians might feel about their validity. Finally, the very concepts of General Psychopathology might be revised in order to represent more adequately patients’ psychopathological reality. For instance, the concept of auditory pseudo-hallucinations adopted by Jaspers underwent recently a meaning-restriction in order to exclude internal auditory hallucinations which have been found indistinguishable from external auditory hallucinations with respect to severity, diagnostic correlates and appropriate treatment. Distinguishing more clearly between the semantics and the epistemology of the concepts and hypotheses of General Psychopathology helps remove Jaspers’ inconsistency and restore the coherence of his classic paper.
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Chasing the Latest Fad: Confronting New and Old Developments in Clinical Psychiatry

Clinical psychiatry has made numerous advances in the past 50 years. Unfortunately, because of the recent emphasis on biological interventions and the financial basis underlying the development of new medications, some investigators seem to chase the latest fad. However, a new treatment cannot be endorsed simply because it is new or it has been adopted by many other professionals. Too many investigators seem to examine recent developments without giving adequate consideration to the logical rationale for the new strategy. The risk of novel approaches will be confronted by examining the theoretical foundation and research support for several new treatments, in light of treatments that were previously praised but quickly discarded. A wide range of innovations will be used to clarify recent and past errors in the treatment of mental illness.

Several important lessons can be learned from a critical review of novel treatments. First, there is no such thing as a panacea. Numerous medications have been found effective in reducing psychiatric symptoms, only to be discarded within a few years, when various side-effects are noticed or the effectiveness wanes. Second, palliative treatments do not result in lasting cures. For most psychiatric problems, reductions in symptoms are merely temporary. Third, a novel approach may be effective, but sometimes the improvement is due to placebo effects and the excitement that often surrounds a new idea. Fourth, theories about etiology often guide plans for treatment. Thus, a strong emphasis on biological factors tends to neglect the cognitive processes, interpersonal relationships, and stressful life events that often influence the etiology and treatment of mental illness. Fifth, many approaches have only short-lived success. Few ideas are right forever. Treatments that are considered safe at one time may be deemed quite dangerous a short time later. Conversely, most “novel” approaches are really minor adaptations of an older strategy. Over the years, there have been numerous ideas that have guided the development of novel interventions, but have faded from our collective memory. The field tends to forget past mistakes. Old treatments quietly fade away, not because they were wrong, but often because they are replaced by a new idea. Clinical psychiatry needs to learn from past mistakes.

In conclusion, it appears that with many new treatments, “scientists were so preoccupied with whether or not they could, they didn’t stop to think if they should.” Empirical evidence alone is insufficient to guide the ethical practice of psychiatry. Too many innovations have been lacking in a sound theoretical rationale. Furthermore, a theory can be devised post hoc to explain almost any intervention. The evidence used to support novel treatments must extend beyond randomized clinical trials and include a sound theoretical foundation, clinical case studies, logical reasoning, and common sense.
Previous research in psychiatric ethics has mainly focused on questions relating to adult patients in coercive care whereas this study widens the field of research. The care staff, in adult and in child and adolescent psychiatric inpatient care had the opportunity to freely describe all kind of ethical considerations at work through ethical diaries. The aim of this study is to analyze the ethical considerations as reported by staff according to fundamental approaches to medical ethics.

The sample was recruited from 13 clinics in Sweden. We invited the staff to keep an ethical diary during one week. 173 persons handed in their diaries. The analysis was made in NVivo 8 with directed content analysis, i.e. the codes are derived from theory or relevant research findings. In this case three different approaches in medical ethics were used as themes to create the codes, here called subthemes. The three approaches were paternalism, autonomy and reciprocity. There were also statements that may be considered as descriptions of situations where staff had inappropriate behavior from a professional perspective and these were also coded.

Paternalism was the most common theme found in the diaries. Statements were coded to this theme when the staff actions were based on their professional responsibility and were justified on the grounds of the patient’s best interests. Some of subthemes were; professional competence and integrity, promote and restore health, care for the patient, and coercion. The staff was expected to be engaged in patient care, while maintaining a professional distance. The theme of autonomy was used for statements where the staff showed respect for patients’ own choices and decisions about medical care and treatment they received. Some of the subthemes were; informing the patient, obtaining informed consent, respect for independence and integrity. The staff reasoned that they should follow patients' wishes about care when it was possible. Few statements were coded in the theme reciprocity. In this theme staff promoted a climate where patients could participate in, and take responsibility for, the care situation. Some of the subthemes were; participation, dignity and mutual understanding. The staff reasoned that they would sometimes break the rules in order to create or maintain a good relationship with the patient. Some of the subthemes in
the theme of inappropriate behavior were; abuse of patients, lying to patients and the objectification of patients. Staff found it difficult to dare to protest when their colleagues demonstrated inappropriate behavior toward patients.

The diaries give a broad picture of how the work in inpatient care is conducted and they have also been used in discussions about ethics with practitioners. This analysis provides new perspectives to the discussion of ethics in psychiatry.
Sexual Perversion and the Paraphilias: The Case of Exhibitionism

In this paper, I will set out some of the basic issues regarding sexual disorders, in the context of my larger project investigating when people with mental illnesses can be held morally responsible for their behavior. Philosophy has a rich literature on sexual perversion, addressing whether it exists, and if so, what makes a sexual interaction perversive, with further discussion of whether perversion is a moral wrong. The relevant debate for us in psychology and psychiatry is over how to classify sexual disorder and what conditions should count as mental disorders. Yet there has been minimal discussion of how these two sets of literature relate to each other. To make the task of understanding the relation of the two approaches more manageable here, I focus on a test case. We will consider the case of an exhibitionist who acts on his sexual urges. This action will count as a perversion on most philosophical approaches that grant the existence of perversion. For example, on Nagel’s (1973) view, normal sex requires that the two people are aware of their mutual attraction and sexual excitement and their sexual excitement is at least partly dependent on their awareness of the other person's sexual excitement. An exhibitionist by definition picks an unsuspecting stranger to expose himself to, often with the intent to shock, although sometimes with the fantasy that the exposure will cause arousal in the other person. There is no actual mutually reinforcing attraction and recognition in these interactions, even when the exhibitionist fantasizes that there will be, and this it will count as perversion. Even more obviously, natural law approaches to sexuality, which link normal sex to sexual reproduction within marriage, will also count exhibition as a perversion. Philosophical accounts of perversions are silent on whether they are medical or psychological disorders, morally bad actions, or whether perversion is simply a *sui generis*. In the psychiatric and psychological literature, it is generally assumed without explanation that exhibitionism is a mental disorder, and while it is acknowledged as a criminal act, there is little discussion of whether the status as a mental disorder means that the exhibitionist is less blameworthy for his actions. In the empirical literature, there is very little evidence-based understanding of what causes exhibitionist behavior, and diagnostic criteria are very behavioral. Most theoretical models of mental disorder propose that what makes the condition a disorder is a malfunction or a problem in the action process. While the exhibitionist performs his characteristic actions with full knowledge of what he is doing, the idea that there is something wrong with him invites the thought that he is not full responsible for his action. I argue that we can bridge the gap between the philosophical and the psychological literatures by examining issues of autonomy and morality more carefully here. I make two main proposals. First: We can draw a distinction between autonomous and non-autonomous exhibitionism: the former is freely chosen action, while the latter results from compulsion or possibly an inability to get sexual satisfaction in other ways. Second: Morally, all exhibitionism, whether autonomous or not, is morally bad because it is offensive and upsetting and treats the person being shocked as an object. In enjoying the discomfort his action causes, the exhibitionist is morally...
at fault, whatever the cause of his action. Nevertheless, lack of autonomy in the behavior does reduce its blameworthiness.
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**The Mind-Body Problem either Undecidable or Materialism is False. Relevance for Treatment of Suicidal Intention.**

Gödel proved that in formal logical systems there are interesting questions that cannot be answered within a given system. In empirical science, questions can be answered empirically. However, the mind–body problem seems not to be empirically answerable because the empirical content of existing mind-body “theories” is inadequate, in that no “theory” seemingly can predict which experiences are possible and which are not. A model to illustrate this point is the “experiences of a Flatlander” for whom it within the context of Flatland cannot be empirically decided if the phenomena exist only in two dimensions or are projections of higher dimensions. But if the Flatlander had a direct experience of the third dimension “he” would then know, even if it’s not possible to prove it to the other still flat Flatlanders.

Non-materialistic views on the mind-body-problem are unscientific in the view of Popper as they cannot be falsified. But the materialistic views, that consciousness is “produced” by body/brain, are equally bad in this respect, in that there seems not to exist any empirical phenomenon that can be observed, in this life before death, which must be accepted as a falsification of the materialistic view.

My first conclusion is then that the mind-body problem is undecidable within existing science.

However there might still be a more empirical approach, which can falsify materialism and therefore decide the question. We can look at the very structure of experience at its basis, namely the number of dimensions that we can experience. In our world, we can experience three independent space directions: length, breadth and height and our physical space and all its material objects are three-dimensional. We can also experience changes in the three-dimensional objects, and thereby experience time. Thus, our world is four-dimensional but we cannot point to any direction of the time dimension. As a thought-experiment we can try to experience a world as a line-lander (who can move just back and forth) and as a flatlander (who can move back and forth, and right and left) compared with us who can move back and forth, right and left, up and down and we can discriminate between these three worlds.

Even if the materialistic belief is that the brain/body can produce all possible experiences is has not been shown how this can be done. A more limited and probably simpler problem would be to demonstrate if and how a three dimensional brain could produce experiences of more than three space dimensions. This problem can be approached in three ways, which together could give a reasonable answer:

1. To construct a theory which shows how a three dimensional structure can produce something with four independent directions of movement. Or by analysis of possible alleged materialistic theories for consciousness show that the project is impossible on logical and mathematical grounds.
2. To construct non-materialistic theories which do explain how we can experience more than three space dimensions.
3. To show that there exist experiences that includes more than three space dimensions.
For example, in near-death-experiences some people see their whole life at once, which can be interpreted as that they experience the fourth dimension, time, as space. In the mathematically possible extension of the special theory of relativity to six dimensions, three space and three time dimensions, consciousness can then reasonably be identified with processes in six-dimensional spacetime, including but transcending the body, and thus the problem of qualia, Chalmers “hard problem”, can be solved. Of course, many interesting problems remain but these are “easy problems” in the Chalmers sense.

In using the cognitive technique of advantages and disadvantages when working with people with suicidal intention the most commonly proposed supposed advantage is “to get rid of everything”. If, as proposed here, the mind-body-problem is undecidable or that materialism is false, I can on strong rational grounds simply ask: “How do you know that?” This often helps the person to see that the alleged advantage is only a belief and then to realize that the disadvantages of suicide outweigh the advantages. Out of over 300 clinical cases four different examples are presented.
Prodromal Diagnosis Delays Early Intervention in Psychosis

Prodromal diagnosis of psychosis appears to be a key to early intervention. Yet current prodromal diagnoses are failing to predict the appearance of psychosis.

The failure of prodromal diagnosis is not a problem of validity. It is a philosophical problem flowing from the mistaken conception of psychosis as a disease process. This mistake comes from the history of the concept of schizophrenia and from misleading analogies with other areas of medicine. The ordinary habits of medical thinking make this mistake difficult to see.

Berrios traces the history of the concept of schizophrenia from tentative description of a phenomenological cluster to the “real, recognisable unitary and stable object of inquiry”; which is the now presumed neuropsychological process or endophenotype needed for the application of empirical science. This is a conceptual misconstruction to which Ludwig Wittgenstein gives some insight. Most psychiatric diagnoses are general terms, like “games” or “knowledge”, which draw together intricate and changeable human behaviours which are not joined as “kinds”, or by a fixed form or any single underlying process. They are important, meaningful and useful concepts but not for causal explanation nor for the application of many scientific techniques. Prodromal diagnosis tries to identify an underlying pathological “process”, which mistakes the conceptual nature of the disease which it seeks.

The mistaken conception of disease derails the clinician’s apprehension of symptoms and the patient’s concordance with intervention. The clinician must deal with the symptoms and signs that are in front of her and not the concept thought to be hiding behind the surface — for “nothing is hidden” yet here the problems are hardest to see.
**A Phenomenological Understanding of Bipolar Disorder**

**Objective:**
Bipolar Disorder (BD) has an influence on the individual's whole life, as well as the life of close relatives. BD is well investigated from a biological and psychopharmacological perspective but poorly explored from the perspective of the individuals actually living with it. The aim of this study was to explore the existential meaning of life with BD.

**Method:**
In order to understand the meaning of the lived experience a lifeworld phenomenological approach\(^1\) was used. Such an approach is well suited for explorations of phenomena that are related to human existence. Data was collected from interviews with ten persons, six women and four men, aged 30–61, who were diagnosed with BD. They were interviewed about their experiences of life with BD. The data analysis was focused on the existential meaning of life with BD and conducted following the structure of whole-parts-whole as described in the chosen research approach.

**Findings:**
Living with BD entails experiencing extra dimensions in all aspects of life, expressed in terms of a magnitude and complexity beyond that which is perceived as pertaining to normal life. All experiences in life are characterized by a specific intensity. Living with BD means an ongoing struggle trying to understand a life in which there is always more to consider. The illness is intertwined with one’s whole being.

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Discussion:
BD has predominantly been understood from a perspective of polarity, i.e. episodes of mood changes alternating between the two extremes of depression and mania. The present study challenges that concept of polarity and suggests that BD must be understood also from a holistic perspective, considering experiences of more inner tension, which is created by the extra dimensions of magnitude and complexity in all aspects of life. Living with BD thus means much more for the individual than having episodes of depression and mania. The current diagnosis BD is a label that only reflects the more obvious and visible dimensions of the illness, excluding the more invisible dimension that causes a large amount of confusion and tension. In addition to conventional treatment adequate care for persons with BD also includes places for safe and profound reflecting about existential issues, such as identity, trust and self-confidence.

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**Ethical Differences and an Ethics of Difference: The Intersubjective Sphere of the Psychiatric Situation**

The precise characterization of the exceptional intersubjective situation of clinical work is of decisive importance for adjudicating the ethical dilemmas of the psychiatric profession. Phenomenological philosophy, through its emphasis on the experience of the interactions between the clinical worker and the psychotic individual, proposes a novel account of these dilemmas and avenues for their resolution.

In my paper, I argue that the unusual challenges of psychiatric work stem from the fact that some of the implicit assumptions otherwise operative in structuring one’s experience of another human being are suspended or perhaps lacking in the clinical setting. I draw on the writings of Edmund Husserl and Emmanuel Levinas to propose a theory of intersubjectivity for these unusual yet meaningful interactions between two individuals. Yet, even though both of these philosophers made contributions to a philosophy of intersubjectivity, these theories require further examination in so far as they apply to a setting in which two fundamentally different modes of relating to others becomes subject to negotiation.

I thus open my paper with a characterization of the intersubjective situation of working with the transference psychoses. Relying on Melanie Klein and Harry Guntrip’s writings — and on their rather useful testimonies about the psychiatrist’s experience of relying on psychoanalytic principles while working with the psychoses — I examine the precise nature of the intersubjective sphere formed in the clinical setting. In my paper, I focus specifically on schizophrenic patients and the psychodynamic theory of the schizophrenias, though my conclusions apply in large part to the psychoses in general.

In view of these findings, I discuss Husserl’s notion of “open intersubjectivity” and the specific ways in which the constitutive foundation for the experience of the other in psychiatric work may become obstructed in the interactions between psychotic and non-psychotic individuals. In my conclusion, I describe an “ethics of difference” inspired by the philosophy of Emmanuel Levinas. Rather than marking the psychotic person as unalterably other, this “ethics of difference” remains true to the experiential evidence of the other participant of the clinical setting, while simultaneously upholding an uncompromising tolerance for the radical alterity upon which its understanding is based. In my paper, I show this approach to be able to promote the same ideals as deontological theories, though in a framework better equipped to speak to the unique ethical issues of the world of psychiatry.
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Pseudohallucinations — A Critical Review

Pseudohallucinations have been one of the least understood phenomena in psychopathology. There exists a lack of consensus in the definition of the phenomenon. By and large there are two trends in defining pseudohallucinations. In the first one proposed by Jasper, based mainly on works by Kandinsky, pseudohallucinations are considered as very vivid sensory images which are different from hallucinations as they lack the characteristic of objectivity and reality. The second definition puts the emphasis on the insight into the phenomenon and defines self-recognised hallucinations as pseudohallucinations. In this paper both definitions are discussed from a phenomenological point of view. After an account on the history of the concept, different aspects of it are explored in detail. Particular emphasis is given to the quality of the perception and its location. Continuity of pseudohallucinations with hallucinations and imagery is examined, so is the similarities with obsessional phenomena. The role of insight in defining pseudohallucinations is debated. The main conclusion is the lack of consensus in defining pseudohallucinations is partly driven by the problems in defining hallucinations. Nevertheless one can conclude that from a phenomenological point of view pseudohallucinations should not be defined as hallucinations with insight. That definition is simplistic and ignores the complexities faced at theoretical and practical levels.
Diversity in Understanding the Psychotic Individual’s Freedom of Belief and Thought

Ethical principles and legislation which guide psychiatric treatment agree that the freedom of belief and thought of psychotic patient should be protected. However, it is unclear how the concept of freedom of belief and thought should be understood and which factors should be noticed when the realization of these rights is evaluated. I will present three different viewpoints to psychotic individual’s freedom of belief and thought. Viewpoints are based on the analysis of discussion concerning human rights, psychiatric ethics and political philosophy.

Classically freedom of belief and thought is understood as a right which realizes when the other people or state do not prevent the individual from holding and manifesting his or her present beliefs and thoughts. From this point of view involuntary psychiatric treatment seems to restrict the psychotic person’s freedom of belief and thought. Legislation guides, for example, to prevent such ideological or religious manifestations which seem to be a threat to patient’s well-being. The other question is whether antipsychotic medication given against the patient’s expressed wishes restricts the person’s right to hold beliefs and thoughts, since the purpose of medication is to influence the person’s beliefs and thoughts, namely delusions.

Secondly, freedom of belief and thought can be understood as “authenticity” or as “autonomous mind”. This viewpoint’s main interest is in the question whether the beliefs and thoughts which the person holds are really his or her own. From this point of view, delusions can be understood as beliefs which are alien to the person who holds them. Therefore, psychotic disorder is seen as a factor which restricts the person’s freedom of belief and thought by distorting his or her belief system as “unauthentic”. Thus, one goal of psychiatric treatment is to return the individual’s freedom of belief and thought.

Thirdly, it can be asked what kinds of resources the person has as a believing and thinking person and how able he or she is to reach his or her ideological goals. If freedom of belief and thought is understood from this point of view, it is interesting how both psychotic disorder and psychiatric treatment increase and reduce the person’s resources. The meaningful question from this point of view is also how state should support the psychotic individual when he or she tries to reach his or her ideological and religious goals.

Diversity in understanding the psychotic individual’s freedom of belief and thought seems to lead to a lack of clear common ethical rules. Since each approach to freedom of belief and thought is problematic, emphasizing one view may also lead in to decisions which seriously restrict the other aspects of the psychotic individual’s freedom of belief and thought. On the other hand, acknowledging the diversity and the problems of different aspects may lead to consider individual situations, hear the patient’s voice and work both multiprofessionally and interdisciplinarily in purpose to understand which aspects of freedom of belief and thought are central in each individual case and why. This way the challenge of diversity may even have consequences which protect the psychotic patient’s human rights as wholeness.
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**Wittgenstein’s Experiment: Attention to Psychotic Expression**

When psychiatrists and academics consider the statements of the floridly psychotic, an unexamined referential view of language, combined with a linguistic climate saturated with empiricism, often creates an over-emphasis on the statements’ relationship to reality. Under these influences all delusional and hallucinatory statements are seen as (mistaken) descriptions of consensual reality, failures in distinction between the real and the contrived.¹

But if we take seriously Wittgenstein’s reminder that all our thinking deals in contrivances, that no sentence, uttered by the mad or the sane, is anchored in reality, but is rather grounded in the logic of our public language, we can begin to see psychotic utterances differently. We all “arrange things experimentally, as they do not have to be in reality,”² and we understand each other because we speak the same language, not because we have checked to see whether or not what is said is in fact true. Because we can understand utterances which may be patently false, or which may even be un-verifiable (like a delusion of spiritual wretchedness), we can attend to their implications, working out what is expressed by those attempting to articulate alienating phenomena.

Forsaking the activity of looking through or behind words to discover the hidden facts our psychiatric conceptions prepare us to see,³ we can respond to patients’ pleas to be heard and understood, even in the midst of severe illness. This kind of attention to patients’ expressions pulls against the generalizing movements necessary for diagnosis, preserving our respect for, and wonder at, the individual enigma of every patient’s insanity, and, for that matter, her sanity as well. It is the kind of work that is always particular, the kind of work in which we cannot, as we might in empirical study, “have the results of another’s labor without the pains of carrying out the investigation.”⁴

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¹ “According to the standard interpretation,” writes Louis Sass in *The Paradoxes of Delusion*, “psychotics are those who fail to distinguish adequately between the real and the imaginary.”


³ Patients’ rights movements (e.g. the Hearing Voices Movement) have described this activity, and its silencing of the patient’s voice, as one of the greatest violences committed by psychiatry against its patients.

⁴ Maurice O’Connor Drury, “1967 Dublin Lecture” in *The Danger of Words and Writings of Wittgenstein*. 

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**Sense of Agency and Ambivalence in Schizophrenia: Interdisciplinary Understanding from Descriptive and Empirical Viewpoints**

The development of basic science has facilitated the controversy on incompatibilities between freedom and determinism for several centuries, while the relationship between free will and ethical responsibility of selection has been mentioned since antiquity. Nowadays neuroscience focuses on the topic of sense of agency, which could touch on this theme of free will.

So far, most scientific researches concentrate on the process of volition and movement, while the mechanism of volition and thought remains mysterious. For example, experimental studies in first-rank symptoms of schizophrenia often mention impaired sense of agency in intentional movements, but such symptoms as thought insertion are not adequately explained.

In the last century analytical philosophy and phenomenological psychopathology discussed that thought should be a kind of action accompanied with volition. The former regarded will not as reason of action but as aspect of action, good or bad. The latter considered thought as praxis inducted by intentionality as well as concerned with language. However, even in these discussions the problem of free will and selection, i.e., how free will in the narrowest sense should be affected by the selection of good or evil will as well as a good or bad sign, is still enigmatic.

In order to elucidate the structure and the dynamics in this sphere of thought and volition, we would like to refer to the concept of ambivalence. This might raise the classic theme of free will as well as new issues of sense of agency with its relationship to selection.

E. Bleuler advanced this concept as one of the fundamental symptoms of schizophrenia in three fields of psychic functions, i.e., emotion, will, and intelligence. Soon after that S. Freud modified and introduced this concept into psycho-analysis, and then importance was attached only to ambivalence of emotion. Freudian application of the concept is, however, fruitful in the connection with recent empirical and scientific researches, for some show empirically significant affective ambivalence in schizophrenia and others point biologically insufficient cerebral area in schizophrenia with the model of ambivalent affect systems. In addition, Freudian theory advocated meta-psychological concepts of life and death instincts, which have analogous aspects to the models of basic-emotional command systems. Thus Freudian determinism may eventually be compatible with neuroscience, but inevitably leave free will unquestioned.

In this presentation the author would like to emphasize the importance of ambivalence of will and intelligence, reviewing philosophical and psychiatric conceptions. This could abstract the relationship between volition and selection in thought and allude to the influence of the some ambivalent system on higher brain functions. In addition, our clinical experiences of ambivalence in schizophrenia shall be presented, which show an irrational inversion between good and evil, suggesting that the specific points in schizophrenia should exist not only in deficient sense of agency but also in disturbed evaluation of agency itself.
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**The Swedish Penal Law System on Criminal Intent in Relation to Severe Mental Disorder and Unaccountability**

Since 1965, committing a crime under the influence of a severe mental disorder has in the Swedish Criminal Code excluded being sentenced to imprisonment. In 2008, this prohibition was changed into a presumption for a sanction other than imprisonment. In accordance with the principal rule now in force, forensic psychiatric care should be the imposed sanction, provided that there is at the time of the judicial decision still a need for such care. If there are particular reasons for doing so, the presumption can be cancelled. However, it must not be cancelled if the offender at the time of the crime was unaccountable owing to a severe mental disorder. The Criminal Code stipulates that being unaccountable implies either of the following: (1) the offender was lacking the ability to understand the meaning of his/her act; (2) the offender was lacking the ability to adjust his/her act according to such an understanding.

The Swedish Criminal Code makes criminal intent (in certain cases negligence) a condition for imposing penal sanction. However, the Criminal Code does not stipulate any particular content for the concept of criminal intent; it is left to the legal usage to work out in detail what should constitute its content. Anyhow, it is assumed that acting under the influence of a severe mental disorder does not exclude acting with criminal intent. In fact, only in a small number of cases per year, where the offender has acted under the influence of severe mental disorder, the indictments are dismissed owing to lack of criminal intent. Strange as it may seem, not even being unaccountable is considered to exclude acting with such intent; consequently, also unaccountable offenders are punishable. How this came about can in rough outlines be explained in the following way. Before 1965, unaccountable offenders were declared exempt from punishment. As a consequence, the issue of criminal intent did not arise with regard to them. When accountability, as a prerequisite of criminal responsibility, was abolished in 1965 and forensic psychiatric care was introduced as the normal penal sanction for severely mentally disordered offenders, criminal intent as a general condition for imposing penal sanction must be applied also to that category of offenders. With the reintroduction of accountability in 2008, as a condition for imprisonment, the wheel has come full circle.

In the presentation it is claimed that the concept of severe mental disorder, as it is used in the Swedish legal system, has been formed on that of accountability, in the sense that severe mental disorders are the ones that compromise the accountability of an offender. The presentation also briefly discusses principles, derivable from sentences passed by the Swedish courts, concerning the alleged criminal intent of offenders who at the time of the crime are severely mentally disordered. One such principle, which at least sometimes seems to be applied, is that criminal intent is to be presumed in these offenders. This is of course inconsistent with the principle that the prosecutor must prove criminal intent.

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Associations of Depression and Anxiety Symptoms with Health-Related Quality of Life in Individuals Infected with HIV in Singapore

Background:
HIV and its complications and comorbidities not only increase the risk of anxiety and depression, but also substantially affect patients’ health-related quality of life (HRQoL). Under-diagnosis of anxiety and depression in HIV/AIDS patients may have a negative impact on patient quality of life and result in disparity between prevalence and the recognition and treatment of these symptoms. The aim of this study was to assess associations of depression and anxiety symptoms with the HRQoL using the EQ-5D and the relationship between depression and anxiety symptoms with markers of disease progression in individuals infected with HIV in Singapore.

Methods:
This was a cross-sectional questionnaire-based study including 132 individuals at least 21 years old, diagnosed with HIV in 2008, who attended the Communicable Disease Centre clinic in Singapore during 1 May 2010—31 January 2011. Study participants were asked to complete the Hospital Anxiety and Depression Scale (HADS) and the EQ-5D questionnaire. The relationships between scores on the HADS, EQ-5D and CD4 counts were assessed.

Results:
Of the 132 individuals, 90.9% were male; mean age was 44.8 years (SD 12.4). 84.8% were Chinese. 81.8% had attained at least secondary school education. 72.0% were employed. 77.3% were on antiretroviral therapy. Median CD4 was 231.5 cells/mm³. On the HADS, 20 (15.2%) had a score of 8-10 and 18 (13.6%) had a score of 11 or more in the anxiety domain. 13 (9.9%) had a score of 8-10, and 9 (6.8%) had a score of 11 or more in the depression domain. 27 (20.5%) had a total HADS score of >14. Patients with higher total HADS score were significantly associated with problems with conducting their usual activities, pain and discomfort and problems with anxiety/depression (p < 0.001) on the EQ-5D. Total HADS score was inversely related to EQ-5Dvas scores (OR 0.95, 95% CI=0.92 - 0.98, p < 0.001). HADS scores were not significantly associated with CD4 counts (p > 0.05).

Conclusion:
These data suggest that depressive and anxiety symptoms in individuals with HIV in Singapore are related to lower patient-reported generic quality of life status. The data
suggest that assessment and treatment for depression and anxiety should be considered for all HIV/AIDS patients, not just those with more severe clinical levels of disease. The potential of the EQ-5D as a screening tool for anxiety and depression in primary care HIV patients also merits study.
The Recovery Model: True or Desirable?

Whilst recovery has been promoted as the proper aim for mental healthcare, there has been little agreement about what it involves. It is, however, often proposed in contrast to a bio-medical view of psychiatric care and is referred to as a recovery model (in contrast to a bio-medical model). In this paper I examine what this claim might amount to by exploring the logical geography of a recovery model.

To count as a model, it must involve a theoretical conception of what ill-health, or health, or something akin to health is. I set out an analogy with a different area of the philosophy of psychiatry. The bio-medical model is sometimes accused of neglect the social aetiology of mental illness. But since one could hold, surely in accord with a bio-medical model, that mental illness consists in failures of biological function whilst nevertheless conceding that this can have distant social causes, a distinct social model of mental illness has to hold that it is constituted rather than merely caused by social factors.

Against that background analogy, and using the distinction between a focus on health versus illness and between evaluative versus plainly factual accounts, I suggest that the recovery model can be thought of as an essentially evaluative conception of mental health (or something akin to it) and examine arguments that that is the most accurate model.

Supporters of the recovery model do not, however, proceed this way. They do not argue for the incoherence, for example, of rival models but rather for the desirability or value of the recovery model. I thus examine the ground rules for this style of argument and examine whether it undermines the initial analogy with a social model of mental illness.
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The Alienation and Anxiety of Endogenous Depressive Patients —
Psychopathologies of “Shuuchaku” (Shimoda) and “Jouissance”
(Levinas)

A depressive episode defined in today’s operational criteria such as DSM comprises
heterogeneous psychopathologies. We consider it still indispensable to elucidate the
specific quality of anxiety found in patients with “endogenous” depressive symptoms.

To achieve this goal I shall focus on alienation, which a German psychiatrist
Gebsattel (1937) pointed out in his patient of depersonalization depression. Not only
in the depressive patients of this type but also in endogenous depression in general,
the patients’ self is, in their depressive phases, alienated from its surroundings with
which it formerly had active communication, as well as from their past self, which was
formerly active. Under this alienation, their present self agitatedly seeks to capture
and regain their past active self in vain. This vicious circle, based on the temporal
disturbance of becoming (Werdenshemmung), composes the specific quality of the
anxiety characteristic to endogenous depression.

The analysis of this specific quality of anxiety also gives a clue to the psycho-
pathologies of patients’ personality structure outside of their depressive phases. One is
“shuuchaku” (a Japanese word meaning sticking), namely the tendency of the patients’
past self, which should have already retreated from the present, being brought back
and sticking to the present. A Japanese psychiatrist Shimoda (1950) considered that
this sticking plays a crucial pathogenic role in the endogenous depression and
elaborated his idea of “shuuchaku temperament” or “statothymia” as a trait of
depressive patients. The other is “jouissance(enjoyment)”. Levinas regarded
jouissance as a fundamental “gustatory” way of communication with surroundings by
human beings. However, in depressive phases, it becomes impossible to maintain this
fundamental communication. This may indicate that although patients’ living outside
of depressive phases is composed of affluent capacity of jouissance (enjoyment), this
very affluence constitutes their insidious susceptibility to endogenous depression.
Hypochondriasis: A Clash of Values over What Constitutes Adequate Evidence?

Hypochondriasis is usually described as a disorder involving excessive anxiety due to a belief or fear that one is ill. Although much research has been devoted to management of patients suspected of suffering from hypochondriasis, comparatively little work has been done to understand why this diagnostic label provokes such intense conflict between patients and clinicians. One possible explanation is that hypochondriasis involves a clash of values over what constitutes adequate evidence for reaching a diagnosis.

Hypochondriasis is often depicted as involving a delusional belief that one is unwell. While criterion A for a DSM-IV diagnosis of hypochondriasis notes that a person must have “preoccupation with fears of having, or the idea that one has, a serious disease based on the person’s misinterpretation of bodily symptoms”, criterion C then adds a disclaimer to criterion A by clarifying that if the patient holds such an idea with delusional intensity, it would then qualify instead as a delusional disorder. This undermines the argument that hypochondriasis should be considered a mental disorder because of the dysfunctional reasoning involved in hypochondriacal beliefs.

Instead, the DSM-IV distinguishes hypochondriasis from normal behavior on the basis that the anxiety persists despite “appropriate medical evaluation and reassurance” and causes clinically significant distress. These criteria are problematic because it is difficult to objectively and reliably assess whether enough evaluation and reassurance have been provided, and clinicians vary greatly in their interpretation of what this entails. Some research has found that strict monitoring of this criterion significantly reduced the estimated prevalence of hypochondriasis. Patients also vary in their interpretation of what constitutes appropriate evaluation and reassurance, and this may be where the source of the conflict lies. Some patients may desire more certainty in the diagnostic process than clinicians are willing to provide. A diagnostic test which rules out a serious illness with 90% certainty may not be perceived of as adequately reassuring by these patients. Consequently, there is a clash of clinician and patient values regarding acceptable uncertainty in diagnosis.

Admittedly, mere disagreement over optimal diagnostic certainty is not enough to earn patients a label of hypochondriasis. Instead, a second conflict of values is involved in these diagnoses, this time having to do with a disagreement over acceptable levels of concern for one’s health. Ironically, the same qualities that are desirable in clinicians are seen as inappropriate when present in patients: intense interest in medical conditions and a passionate desire to correctly identify symptom etiology. Patients who receive a diagnosis of hypochondriasis are those who both desire greater certainty and express significant distress when they are unable to receive this certainty.

Clinical pragmatism calls into question the use of a diagnosis that elicits patients’ automatic rejection of both the label and its associated treatment. Similarly, a values-based approach to medicine would favor a non-judgmental attitude towards patients’ dissatisfaction with the level of certainty provided in standard medical visits. Imposition of psychiatric labels is usually limited to cases where patients pose a threat to themselves or others. In the case of hypochondriasis, these justifications seem to be absent, and use of the this label against patients’ wishes might be better explained by patients’ violation of moral norms and the demands they impose on community
health resources. Although it may be just and necessary for health care systems to set limits on the use of diagnostic tests and treatment, mental disorder labels should not be used to discredit patients solely because they disagree with clinicians about the amount of evidence they wish to have when ruling out a diagnosis and how greatly they are distressed by inadequate evidence.
Psychiatry and Reality — Perception of Matter or Matter of Perception?

Current concepts of delusion largely rely on the assumption that one single objective external reality exists as a benchmark for our internal experiences. With the advent of quantum theory holding that reality within the atom is probabilistic and observer-dependent this assumption has become untenable. Accepting the Copenhagen interpretation of quantum theory that there is no reality beyond what is revealed by the act of measurement or observation ultimately implies that there is no objective reality. But this deduction that reality, in general, is thus informational rather than material in nature seems absurd and incompatible with our daily experience. Defining macroscopic reality is not easy though. Scientific realism claims that objects of scientific knowledge exist in an objective world. Antirealism challenges this notion of an objective reality. One alternative interpretation of quantum theory is the “many worlds” interpretation which finds its philosophical correlate in the “plurality of worlds” theory. This holds the idea of all possible worlds being not just possible but real.

Accepting reality as a probabilistic — a cloud — rather than a deterministic concept — a clock — would be compatible with the uncertainty commonly experienced in medical research and practice. In most branches of medicine we would have no difficulties in accepting that the recognition and interpretation of clinical signs and symptoms is inevitably prone to measurement error, random or not. We understand that a true value may lie within a range of possible values depending on a predefined probability level. But what is an acceptable balance between false positives and false negatives? Diagnosis of psychosis based on positive symptoms alone remains difficult where views on reality clash. The problem partly stems from the tendency of our current diagnostic classification systems to be instrumentalist; that is essentially concerned with reliability and prediction. However, most criticism of psychiatry is concerned with validity and explanation, hence strictly constructivist. The constructivist would consider psychotic symptoms social constructs, man-made and prone to abuse in settings intolerant to minority views. With the advent of the information revolution, setting a gold standard for truth and reality will most likely become more, not less difficult. Psychiatrists when explicitly asked seem to agree. But the implicit acceptance of reality in largely deterministic and instrumentalist terms has instilled today’s generation of mental health professionals and policy makers with a false sense of security that the diagnosis of delusion and psychosis is straightforward. Highlighting uncertainty as one important principle in psychiatry may be useful, particularly if we accept that life events may be much more prone to random effects than commonly purported.

Even if we believed in one single objective external reality as a benchmark for our internal experience we would still never experience this reality directly. Our experience of reality is essentially one of virtual reality as generated by our brain. This virtual reality may be due to pathological cognitive processes but this does not invalidate the experience. Thus, it will finally become necessary to rethink our currently accepted concept of psychosis. This will become inevitable by the time we
master technologies to create sophisticated virtual reality environments individualizing human experience. However, until we have moved to a better understanding of reality, meticulous history taking coupled with accurate clinical observation and professional empathy remains the best way to account for its uncertain nature. Currently, it remains the only way to explore whether a belief or conviction can ultimately be understood or not.
Galen Strawson, in his celebrated article “Against Narrativity,” provides a compelling argument for rejecting both the descriptive claim “that human beings typically see or live or experience their lives as a narrative or story of some sort” and the normative, ethical claim that “a richly Narrative outlook is essential to a well-lived life, to true or full personhood” (Strawson 2004: 248). He goes on to elaborate a distinction between diachronic and episodic self-experience, where narrative, form-finding, storytelling, revisionist diachronic self-experience is opposed to the “deeply non-Narrative” but still profoundly rich experience of the episodic self. Although widely debated in other contexts, the implications of Strawson’s argument in the case of psychopathology broadly, and schizophrenia specifically, have not yet been adequately explored.

The idea that people diagnosed with schizophrenia tell fragmented, impoverished, or otherwise faulty narratives has been elaborated from a number of different philosophical and clinical perspectives (Lysaker and Lysaker 2002; Gallagher 2003; Phillips 2003; Gruber & Kring 2008; Saavedra et al. 2009). From a phenomenological perspective, these ‘problematic’ narratives point towards disturbances in two levels of human temporality: the implicit or lived time associated with a basic sense of self or ipseity, and the explicit or experienced time registered by the “extended, personal or narrative self” (Fuchs 2011).

The key question addressed in this paper is: can Strawson’s critique of Narrativity and his account of episodic self-experience contribute to the phenomenological account of narrative disturbances in schizophrenia?

This paper will argue that there is a role for Strawson’s account of episodic self-experience in complementing, rather than contesting, phenomenological accounts of temporal experience in schizophrenia. Where Strawson’s work proves helpful is in distinguishing narrative capacity from the propensity to narrate; a distinction which enables us to account for otherwise paradoxical artefacts (such as autobiographies of schizophrenic experience; see MacKenzie & Poltera 2010). Perhaps more importantly, Strawson’s critique of Narrativity, his rejection of the view that personhood depends on a richly narrative identity, provides grounds for rejecting the disturbing claim (articulated by Phillips 2003) that persons diagnosed with schizophrenia are, by virtue of “disturbances” of narrative capacity, no longer really persons.
Depressive and Anxiety Symptoms in Primary Family Caregivers of Palliative Care Patients in Singapore

Prevalence of depression has been found to be between 20 to 50 percent in American and European family caregivers. Cultural differences are likely to influence how one responds to the stress of caregiving.

The main aim of this study was to estimate the prevalence of depressive and anxiety symptoms in a local population of primary family caregivers of palliative care patients with cancer. The secondary objectives were to identify factors that were associated with increased risk of depressive and anxiety symptoms.

35 family caregivers were recruited via a home care service in Singapore. The family caregivers completed the Hospital Anxiety and Depression Scale (HADS). Presence of depressive and anxiety symptoms were defined as a score of $\geq 8$ on the HADS depression and anxiety sub-score respectively. Of the 35 caregivers analyzed, 51.4% (n=18) had depressive and 48.6% (n=17) had anxiety symptoms. 71.4% (n=25) had depressive and/or anxiety symptoms. A caregiver with physical illness has 4.767 higher odds of having anxiety symptoms ($CI = 1.137–19.977, p = 0.033$), compared to a caregiver without physical illness.

Prevalence of depressive and anxiety symptoms were high in this group of family caregivers. A caregiver with a physical illness has a higher risk of anxiety symptoms. Findings support the importance of screening for psychological distress and improved support for caregivers.
Automatic and Cognitive Empathy: A Contemporary Approach to Jasperian Empathic Understanding

Karl Jaspers was the first major author who emphasized empathy as the proper method of the phenomenological approach to human psychopathology. He divided mental symptoms into subjective and objective ones, stressing the crucial importance of the former. Subjective symptoms are mainly those expressing patients’ emotions as well as those experienced by them and verbally communicated during the diagnostic interview. Whereas the expressive symptoms are grasped immediately by clinicians, the understanding of the experienced ones is mediated by patients’ verbal communications as re-experienced or actualized in clinicians’ own consciousness. Thus, Jasperian empathic understanding or actualization is a two-fold process: the first is a direct and automatic one, whereas the second is an effortful process of “feeling oneself into other's condition” or of “immersing oneself in other people’s self-description” which has to be learned by systematic and rigorous training. Both processes provide the core of what Jaspers called “static understanding” and prefigure two main types of empathy emerging from contemporary scientific research in neuroscience and social psychology, namely “automatic emotional empathy” and “cognitive empathy”. Automatic emotional empathy refers to an automatic direct process of understanding other people’s emotional state. According to recent neuro-scientific findings, the observation of another person’s facial expressions and gestures expressive of her current emotional state activates observer’s system of mirror neurons and through this system, other brain areas generating the same emotional state. As a result, the emotional state of the observed person becomes directly understandable and felt, by the observer. Thus, mirror neurons provide the basis for the empathic understanding of our fellow humans in general and of mental patients’ emotions by clinicians in particular. However, though necessary, automatic emotional empathy is a rather “general” and non-specific capacity, helping to grasp with high accuracy though not infallibly mainly only primary emotions. As such, it is not sufficient for a comprehensive diagnostic assessment of mental patients’ complex abnormal experiences, which requires a far more refined and educated type of understanding. Cognitive empathy refers to the capacity of “imagining how one would feel and think in the other’s place”. In contrast with the automatic type of empathy, cognitive empathy is a non-automatic process which requires an “imaginative” capacity, as well as a reasoning capacity of integrating other’s life events, thoughts and feelings. This equally indispensable type of empathy can be cultivated not only through sustained clinical experience, but also through psychiatrists’ study of the arts and humanities, especially literature. Several psychopathological symptoms that psychiatric patients describe to their psychiatrists are never experienced by the later. Even further, some psychopathological symptoms are in an “out of normal experiences” spectrum and thus may not be ever experienced by them. Thus, even if necessary, this type of empathy is not sufficient for the patients’ experiences to be fully understood. Some research has been conducted on testing clinical psychologists’ empathic accuracy. Training and refinement of this type of empathic understanding helps improve the accuracy of psychiatric assessments.
Life Force Discourses. From Vitalism to Biopower and joie de vivre

The paper has the rise and fall of vitalism (from Latin *vita*, life) as its guiding idea, together with an ambition to link it to current bioscience, psychiatry and discourse analysis.

Historically vitalism can be traced back to Aristotle and Spinoza, but its high tide was the 19th century. It was the belief that human beings are not merely physical, but also contain a spiritual component or vital essence. These ideas are considered by modern bioscience to be without genuine explanatory power.

Henri Bergson’s neovitalist thinking about the creative evolution and the life force (*élan vital*) became influential as an essentially metaphysical reaction to determinism, which survived well into the 20th century, especially among psychologists, poets and artists. As *Lebensphilosophie* it might be regarded as an intellectual orientation and not a hypothesis in need of material proof. For instance the Scandinavian psychiatrist Poul Bjerre argued that in a world dominated by materialism, a physician should also be a humanist. Art and other cultural activities were recognized as tools for the creation of a health-promoting environment.

In sum: The humanist discourse is relevant for a critique of the focus on genetics, diagnostics and pharmacy, that mark the psychiatric theory in the contemporary scene. The reductionistic tendencies within modern bioscience also raise important ethical and political challenges.